Maternal and Child Health Services Title V Block Grant

State Narrative for Missouri

Application for 2010
Annual Report for 2008

Document Generation Date: Monday, September 28, 2009

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

By signing the Application Face Sheet (Standard Form 424) the Director of the Division of Administration of the Department of Health and Senior Services (DHSS) assures compliance with certifications and assurances for non-construction programs, debarment and suspension, drug-free workplace, lobbying, Program Fraud Civil Remedies Act (PFCRA), and environmental tobacco smoke. The SF424 is submitted electronically through the HRSA EHB/TVIS Web-based system. A copy of the signed SF424 and certifications and assurances may be obtained from Division of Community and Public Health, MO DHSS, P.O. Box 570, 930 Wildwood Drive, Jefferson City, MO 65102-0570.

No Maternal and Child Health (MCH) population groups targeted to receive MCH Block Grant supported services are denied services based upon their ability to pay. DHSS's policy is firmly committed to compliance and enforcement of all federal and state regulations that forbid discrimination in delivery of services to clients and patients served by the DHSS programs. (EEO/AA, Nondiscrimination; Executive Order 11246; Governor's Executive Order 94-03)

The DHSS professional and special services agreement with providers of services to MCH populations states the provider shall not require or request payment for authorized services from clients covered by this agreement. (MO DHSS Participation Agreement for Professional and Special Services Provider, MO 580-1302 (04-06))

/2009/
The updated MO DHSS Participation Agreement for Professional and Special Services Provider, is now MO 580-1302 (10-06).
//2009//

The Single Audit (Single Audit Act of 1996) may be located at the Federal Audit Clearinghouse (http://harvester.census.gov/sac/). The MO State Auditor's audit to meet this requirement may be found at http://auditor.mo.gov/auditreports/default.htm.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Public input was an essential element in the development of this application. The process for obtaining public comments included placing the Proposed Use of Funds document on the Department's Web site (www.dhss.mo.gov) and electronic notification of location of Proposed

Use of Funds sent to key stakeholders including Family Partners, DHSS management and all 114 local public health agencies (LPHAs). An article was placed in weekly electronic newsletter "Friday Facts" prepared by Center for Local Public Health Services (CLPHS) (http://www.dhss.mo.gov/fridayfacts/).

Responses were received from individuals and maternal and child health stakeholders throughout the state. Injury prevention was the primary concern. These were reviewed and incorporated into the plan where appropriate.

In addition to the 11 responses received, the DHSS Web site with the Proposed Use of Funds had a total of 107 hits, internally and externally.

/2009/
The process for obtaining public comments and processing inquiries continued as in previous years.

Ads were placed in the St. Louis, Kansas City, Springfield, Columbia, and Cape Girardeau newspapers to notify public of the document on the Web and contact to request hard copies. The DHSS Web site with the Proposed Use of Funds had a total of 206 hits, 45 internally (includes LPHAs) and externally (161).
//2009//

/2010/
The process for obtaining public comments and processing inquiries continued as in previous years.

Proposed Use of Funds was posted on the DHSS Web site from May 12, 2009 through June 15, 2009. The web site had 100 hits, 1 internal (includes LPHAs) and 99 external.

Ads were placed in 6 newspapers in St. Louis, Kansas City, Springfield, Columbia, Kirksville and Cape Girardeau to notify the public the document was on the Web and the contact information to request hard copies. Notice was included in the DHSS, Friday Facts three times in May 2009. E-mails notifications were sent to 417 various public contacts including council members, community partners, health care professionals and industry leaders.

One comment was received on the Proposed Use of Funds. It encouraged additional investments in early childhood, especially preventative services.
//2010//

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

An attachment is included in this section.

C. Needs Assessment Summary

Since 2005 when state general revenue reached fiscal bottom for MCH services, DHSS/Division of Community and Public Health (DCPH) supported its MCH programs within budgetary plateau. DHSS's Office of Epidemiology issued State of Missourians' Health Report identifying 10 key population health indicators for comparison of Missouri's overall health status with the nation. Among indicators where Missouri fared worse than the nation were these indicators of growing concern to Missouri Title V agency:

-Infant Mortality (disparities in birth outcomes)
-Obesity
-Smoking (tobacco use)

/2008/
Lack of access to primary care delivery networks (overriding MCH priority need identified in 2005) for large segments of MCH population in Missouri continues in 2007 with absence of pediatric dentists in rural areas of critical concern.
//2008//

/2009/
MO Title V agency recognizes large segments of MCH population still lack access to primary care delivery networks with absence of pediatric dentists in rural areas of critical concern. UMKC Institute for Human Development recently completed surveys and related analysis of primary care recruitment and retention activities.
//2009//

/2010/
Missouri continues to work towards improving the health of women, infants, children, youth and families with a focus on utilization of local health care providers, local public health agencies, schools and child care facilities. Title V holds an innovative contract with 113 of the 114 local public health agencies which requires the completion of a community assessment, and implementation of evidence based or best practice(s) for a single focus area, choosing tobacco prevention/cessation, obesity prevention or injury prevention. Based on the CDC's model, the School Health program requires all contractors to assess their community using the School Health Index and to work with their School Health Advisory Committee to determine a plan for improvement for the school community. The Child Care Health Consultation and MO Child Care Resource and Referral Programs also focus on the needs of a specific community/facility and provide educational sessions for parents on a variety of topics including tobacco prevention, obesity prevention, and injury prevention to name a few.

The CSHCN program collaborates with the University of MO Kansas City on the implementation of the Family to Family and CYSHCN Community Integration grants. These grants assist the program and state to improve the infrastructure for all cyshcn in MO. In addition, the program works very closely with the University of MO-Columbia on their HRSA/MCHB Autism grant. The Title V Director serves on the University's Autism Center Board of Directors, the CSHCN Director serves on the Autism Grant's Advisory Council and the CSHCN Program Manager works on the Autism Rapid Response team developing

training materials for health care providers and case managers.

Recognizing that approximately half of all births are to women who are Medicaid recipients, the Title V programs work collaboratively to improve the health outcomes of this population. The Title V Director serves on the Medicaid Managed Care Quality Assurance Committee and provides feedback to the Managed Care Plans on their performance. In addition, the Title V Director serves as a liaison between the Title V Programs and the Medicaid Managed Care Plans.

During this past year, the Medicaid program has faced challenges in the area of access to care (including assurance of an adequate number of health care\dental providers and informing participants of the benefits available to them) and fully demonstrating the impact of the program (assuring health care\dental providers bill Medicaid for their services rather than doing them free of charge in order to benefit their tax status). Each plan is required to have Performance Improvement Plans to improve utilization of dental benefits and improve early entry into prenatal care. Through these efforts, the Medicaid Managed Care Plans have implemented creative interventions such as use of a "Dental Exam Prescription" given to parents when they bring their child in for a "well child" examination, and home visits & cell phones for hi-risk pregnant women.

Health disparities continue to be evident in MO. The state's very low birth weight, low birth weight, and neonatal death rates are all approximately 2-3 times higher in the African American population as compared to whites. In addition, it is noted that pregnant women on Medicaid are less likely to enter prenatal care in the first trimester, nor receive adequate prenatal care according to the Kotelchuck Index. Access to care issues surround these statistics, as the largest FQHC in southeast MO does not have a OB/GYN physician on staff. MO has discussed utilization of the Lifecourse Perspective in program implementation and could benefit from technical assistance in this area. The Title V programs have been working with the Department's Office of Minority Health on a Infant Mortality grant that focuses on the St. Louis area. Plans for the upcoming year include a social marketing campaign addressing infant mortality preventive messages to this area which has one of the highest rates.

Obesity rates continue to be of concern in MO. The 2007 PedNSS survey reports 13.7% of 2-5 year olds in WIC are overweight, 11.9% of middle school and 12.3% of high school youth are overweight (MOYTS 2007) and 37.5% of women report being 20% or more overweight before becoming pregnant. This data obviously has great implications for the pre-conception population. Unfortunately, MO no longer has a CDC Obesity grant and some activities were not continued. The WIC program continues to revise the food package and it is hoped this will lead to fewer obese young children who retain a healthy weight throughout the lifespan.

Smoking continues to be a primary concern to the Title V programs as seen in the continued decline or delayed improvement in some performance measures. MO is known to have the second lowest state tobacco tax in the country. In the past 5 years, 2 attempts to pass a higher tobacco tax have been put to the voters of the state and failed. The most recent attempt failed by a very small margin, but the general consensus of the elected officials on this matter is "the people have spoken". Therefore, it is not surprising to find 18.4% of women responding to the PRAMS survey report having smoked in the last 3 months of pregnancy and 24.5% of adults participating in BRFSS report they currently smoke (the 4th highest rate in the nation). Youth in middle and high school also report rates higher than the national average. Recognizing the impact of smoking on health, the General Assembly appropriated $1.7 million for youth tobacco prevention/cessation interventions that are evidence-based. Additionally, the Title V and Chronic Disease programs are working with the Medicaid program on efforts to reduce the smoking rates for all Missourians, especially pregnant women.

Like other states, MO is facing a budget shortfall and anticipates the need to fund additional personnel with Title V funds. It is hoped that despite this economic picture we are able to meet our objectives for the coming year.
//2010//

III. State Overview

A. Overview

A.1. DEMOGRAPHIC PROFILE

Selected demographic information from U.S. Census Bureau for Missouri can be located under Section II, Needs Assessment under B. Five Year Needs Assessment, 3.1. MCH Demographic Overview. It compares Missouri's population with the United States in regard to age, race/ethnic distribution and educational attainment. Also 3.2. Benchmark Analysis compares maternal and child health related indicators among states similar to Missouri.

/2007/
For the entire 2005 Needs Assessment, go to:
https://perfdata.hrsa.gov/mchb/mchreports/documents/NeedsAssessments/2006/MO-NeedsAssessment.pfdf.

Section II of this 2007 application/2005 report has an attachment with an update to the matrix of the comparison of the performance measures, health systems capacity indicators and state priorities that was included in the Needs Assessment.
//2007//

Based upon "Growth in the Heartland: Challenges and Opportunities for Missouri" by the Center on Urban and Metropolitan Policy at the Brookings Institution report copyrighted 2002, Missouri grew in the 1990s but significant growth has stalled since 2000. The state's population decentralized with the population and job gains moving beyond metropolitan areas. With the decentralization came the increase in the capital and operation costs for roads, sewer and water infrastructure, schools and police and fire services; a serious water quality problem in the Ozark lakes due to septic seepage; damage to Ozark lakes and landscapes which threaten a $1.6 billion tourist industry; high-capacity roads in need of building and maintenance; and isolation of low income and minority Missourians from opportunity as middle-class residents and employment move out to suburban/rural areas.

"Growth in the Heartland" concluded that while Missouri had enjoyed enviable growth in the nineties and many new residential communities had sprouted up during that decade, a slowing economy in the new century raises many questions concerning how best to support the needs of communities that are increasingly dispersed geographically. Missouri's metropolitan areas are all experiencing the "open country" shift of their core populations shrinking as growing numbers of residents leave the central city and even older suburban areas for newer residential developments away from urban congestion.

/2009/
Previous demographic trends in Missouri have continued and accelerated in the early part of this century. Missouri's metropolitan areas are all experiencing the "open country" shift of their core populations shrinking as growing numbers of residents leave the central city and older suburban areas for new residential developments away from urban congestion. With this demographic shift, job gains for Missouri have also move beyond Missouri's older metropolitan areas. The current population of Missouri is 85.4 percent white and 11.5 percent African American. Nationally, the population is 80.4 percent white and 12.8 percent African American. People of Hispanic origin make up 2.6 percent of Missouri's population. Between 1996 and 2006, Missouri's population grew by 7.6%. Of all racial and ethnic groups, Hispanics had the fastest growth rate at 94.4%. During this period of time the Hispanic population more than doubled in 56 of the counties in Missouri.

The Office of Management and Budget (OMB) is now following a new classification system for defining metropolitan population centers versus "non core areas in any given state. Under this

new system, a category of "micropolitan" area has emerged. Such areas are considered to be growing population centers of 10,000 to 49,999 and surrounding counties that are linked through commuting ties. These micropolitan counties are becoming "rural trade centers and are increasingly important to the overall economic vitality of non-urban Missouri. " Studies conducted by the Institute for Public Policy have also concluded "the cost of living in many non core areas may not be as high as the more urbanized metropolitan counties." From 2000 to 2005, the population growth that Missouri experienced in the 1990s has slowed considerably. During this time period, Missouri lost population in 37 counties with many of those counties being in the Northern rural sections of the state. Only eight Missouri counties had population gains of 10 percent or more during this time period, 7 metro and 1 micropolitan county. The largest population gains during this time period were in the Springfield area and the St. Louis area. In 2005, there were 18 Missouri counties where persons 65 and older accounted for 20 percent or more of the total population. "These 18 counties (all non-metro) may be aging due to out migration of younger populations, likely in the northern part of the state, or due to the in-migration of older, retirement aged populations, likely in areas surrounding the Lake of the Ozarks and Branson.

A more focused analysis of demographic trends and shifts within MCH population groups is now underway; the results of which will be reported in the 2010 Five Year MCH Needs Analysis. //2009//

/2010/
Past demographic trends in Missouri have continued and accelerated in the early part of this century. Missouri's metropolitan areas are all experiencing the 'open country' shift of their core populations shrinking as growing numbers of residents leave the central city and older suburban areas for new residential developments away from urban congestion.

Missouri's population estimate for 2007 was 5,878,415. In 2007 Missouri's population was estimated to be 86.5% white and 13.3% African American. People of Hispanic origin make up 3.0% of Missouri's population. This is a much smaller ratio compared to national figures where Hispanics consist of 15.1% of the population. Between 1997 and 2007 Missouri's overall population grew by 7.3%, while the national average during that same time period was 10.5%. During this same period the Hispanic population statewide nearly doubled, increasing by 94.9% (86,853 persons). From 2000- 2007 the Asian/Pacific Islander population increased by 33.5%, and the American Indian/ Alaskan Native population increased by 9.6%.

From 2000 to 2007, the population growth that Missouri experienced in the 1990s has slowed considerably. From 1993-2000 the growth rate in Missouri was 6.2%. During the 2000-2007 time period the growth rate slowed to 5.0% and was unevenly distributed throughout the state. Using the new Office of Management and Budget (OMB) classification system, metropolitan counties in Missouri increased 5.96% from 2000-2007. Micropolitan counties, defined as growing population centers of 10,000 to 49,999, increased by 4.58%. However rural counties, defined as all counties that were not classified as metropolitan or micropolitan, increased by a mere 0.64%. Overall, 43 of Missouri's 115 counties lost population during 2000-2007. Rural counties north of the Missouri River were the ones most likely to suffer population loss. Nineteen of the 21 counties that met this geographic definition lost population during 2000-2007 period. Overall, 15 counties saw large (>10%) population increases from 2000-2007, twelve of which were classified as metropolitan counties and 3 as micropolitan counties. //2010//

Missouri is the 17th largest state in the nation based on the 2000 Census. In the year 2000, Missouri's population was 5,595,211; by 2003, the total population of Missouri was 5,704,484. Of the total Missouri population in 2000, it was estimated that 84.9% of persons living in Missouri were white; 11.2% were African American and 3.9% were of other racial groups. It was estimated

that in 2003 there were 130,928 Hispanics living in Missouri, an increase of 9.3% over 2000 census numbers; the total percentage of whites living in Missouri increased slightly by 1.2% during this time period; and the percentage of African-Americans within the total population had increased by 3.6% from the 2000 census. In 2000, the percentage of the population who were Asian/Pacific Islander increased 55.1% since 1990 from 41,758 to 64,773 in 2000. By 2000, American Indian/Alaskan Native population grew 24% from 1990 to just under 5.6 million in 2000.

/2007/
All population estimates are from DHSS Population Missouri Information for Community Assessment (MICA) (http://www.dhss.mo.gov/PopulationMICA/). In the year 2004, Missouri's total population was 5,754,618. Of the Missouri population in 2004, it was estimated that 86.1% of persons living in Missouri were white, 11.8% were African-American and 2.0% were of other racial groups. In 2004 there were an estimated 148,201 Hispanics living in Missouri (2.6% of all Missouri residents), an increase of 25.0% over 2000 numbers. The number of whites living in Missouri increased by 2.4% during this time period and the number of African-Americans increased by 4.7% from the 2000 Census. The number of Asian/Pacific Islanders in Missouri grew by 16.5% from 72,798 in 2000 to 84,820 in 2004. By 2004, the American Indian/Alaskan Native population stood at 32,296, a growth of 1.9% from 31,697 in 2000.
//2007//

/2008/
All population estimates are from DHSS Population MICA (http://www.dhss.mo.gov/PopulationMICA/). Missouri's population estimate for 2005 was 5,800,310. Of the Missouri population in 2005, it was estimated that 86.1% of persons living in Missouri were white, 11.9% were African-American and 2.0% were of other racial groups. In 2005 there were an estimated 155,519 Hispanics living in Missouri (2.7% of all Missouri residents), an increase of 31.1% over 2000 numbers. The number of whites living in Missouri increased by 3.1% during this time period and the number of African-Americans increased by 5.9% from the 2000 Census. The number of Asian/Pacific Islanders in Missouri grew by 21.5% from 72,301 in 2000 to 87,856 in 2005. By 2005, the American Indian/Alaskan Native population stood at 30,639, a decline of 2.7% from 31,480 in 2000.
//2008//

/2009/
All population estimates are from DHSS Population MICA and the CDC (http://www.dhss.mo.gov/PopulationMICA/ and http://www.cdc.gov/nchs/about/major/dvs/popbridge/datadoc.htm).

Missouri's population estimate for 2006 was 5,842,713. Of the Missouri population in 2006, it was estimated that 85.9% of persons living in Missouri were white, 11.9% were African-American and 2.2% were of other racial groups. In 2006 there were an estimated 164,194 Hispanics living in Missouri (2.8% of all Missouri residents), an increase of 38.5% over 2000 numbers. The number of whites living in Missouri increased by 3.6% during this time period and the number of African-Americans increased by 7.1% from the 2000 Census. The number of Asian/Pacific Islanders in Missouri grew by 32.6% from 71,869 in 2000 to 95,285 in 2006. By 2006, the American Indian/Alaskan Native population stood at 33,362 an increase of 4.7% from 31,876 in 2000.
//2009//

/2010/
All population estimates are from DHSS Population MICA and the CDC (http://www.dhss.mo.gov/PopulationMICA/ and http://www.cdc.gov/nchs/about/major/dvs/popbridge/datadoc.htm).

Missouri's population estimate for 2007 was 5,878,415. In 2007 Missouri's population was estimated to be 86.5% white and 13.3% African American. People of Hispanic origin make up 3.0% of Missouri's population. This is a much smaller ratio compared to national

figures where Latinos consist of 15.1% of the population. Between 1997 and 2007 for all persons Missouri's population grew by 7.3% while the national average during that same time period was 10.5%. During this same period the Hispanic population statewide nearly doubled, increasing by 94.9% (86,853 persons). From 2000- 2007 the Asian/Pacific Islander population has increased by 33.5%, while the American Indian/ Alaskan Native population increased by 9.6%.
//2010//

In Missouri, the population of women of childbearing age in 2000 was 1,206,615. In 2005, that population is estimated to decrease by slightly more than two percent to 1,181,916. Most of this decrease is in the 35-44 year old age cohort. Between 1998 and 2003, the number of live births among whites increased by 1.9% and the number of births among African-Americans for the same period declined by 3.1%. Between 1998 and 2003, the total number of births in Missouri increased from 75,242 to 76,960. During this period of time, the number of births among mothers eligible for Medicaid increased from 28,847 (38.3% of total births) to 33,436 (43.5% of total births).

/2007/
All population estimates are from DHSS Population MICA (http://www.dhss.mo.gov/PopulationMICA/). In Missouri, the population of women of childbearing age (ages 15-44) had increased by only 0.3% to 1,209,678. During the 2000-2004 period, the 15-24 age cohort increased by 5.5% while the 25-44 age cohort decreased by 2.2%. Between 2000 and 2004, the number of live births among whites increased by 1.5% and the number of live births among African-Americans for the same period declined by 1.5%. Between 2000 and 2004 the total number of live births in Missouri increased from 76,329 to 77,709. During this period of time, the number of births among mothers eligible for Medicaid increased from 30,029 (39.3% of total births) to 35,424 (45.6% of total births).
//2007//

/2008/
In Missouri, the population of women of childbearing age (15-44 years) in 2000 was 1,206,448. This population grew by slightly over 0.3% to 1,210,334 in 2005. An increase of 4.1% in the 15-34 age cohort during this period was offset by a decline of 6.1% in the 35-44 year old age cohort of this population. Between 2000 and 2005, the number of live births among whites increased by 2.3% to 64,136 and the number of births among African-Americans for the same period increased by 0.2% to 11,455. Between 2000 and 2005, the total number of births in Missouri increased 2.9% from 76,329 to 78,547. During this period of time, the number of births among mothers eligible for Medicaid increased from 30,029 (39.3% of total births) to 36,775 (46.8% of total births).
//2008//

/2009/
In Missouri, the population of women of childbearing age (15-44 years) in 2000 was 1,206,448. This population grew by 0.7% to 1,197,935 in 2006. An increase of 3.8% in the 15-34 year age cohort during this period was offset by a decline of 8.3% in the 35-44 year old age cohort of this population. Between 2000 and 2005, the number of live births among whites increased by 5.3% to 65,987 and the number of births among African-Americans for the same period increased by 8.0% to 12,347. Between 2000 and 2006, the total number of births in Missouri increased 6.6% from 76,329 to 81,353. During this period of time, the number of births among mothers eligible for Medicaid increased from 30,029 (39.3% of total births) to 37,985 (46.7% of total births).
//2009//

/2010/
In Missouri, the population of women of childbearing age (15-44 years) in 2000 was 1,206,448. This population decreased by 1.2% to 1,191,646 in 2007. An increase of 3.8% in the 15-34 year age cohort during this period was offset by a decline of 9.7% in the 35-44

year old age cohort. Between 2000 and 2007, the number of live births among whites increased by 5.4% to 66,103 and the number of births among African-Americans for the same period increased by 10.8% to 12,665. Between 2000 and 2007, the total number of births in Missouri increased 7.3% from 76,329 to 81,883. During this period of time, the number of births among mothers eligible for Medicaid increased from 30,029 (39.3% of total births) to 38,344 (46.8% of total births).
//2010//

The size of the under age five group shrank from 11% of the state's total population in 1960 to 6.6% in 2000. Population forecasts predict it will shrink to an estimated 6.3% in 2020, to 382,000 children, fully 84,000 less than in 1960. The 5-13 age group also declined dramatically between 1960 and 2000, falling from 17% to 12.8% of the total population. By 2020, this age group will number an estimated 689,000 or 110,000 less than in 1960 due to an aging population and couples having fewer children. The 15-17 age group is somewhat larger than it was in 1960, numbering an estimated 304,000 persons in 2005. This age group is projected to fall to 292,000 persons in 2020.

/2007/
All population estimates are from DHSS Population MICA (http://www.dhss.mo.gov/PopulationMICA/). The size of the cohort under 5 years of age shrank from 10.8% of the State's total population in 1960 to 6.5% in 2004. The 5-13 age group also declined dramatically between 1960 and 2004, falling from 17.1% to 12.2% of the total population. Though the 15-17 age group is larger than it was in 1960, numbering an estimated 245,096 in 2004 (29.4% of the total population), compared to 194,153 in 1960 (4.5% of the total population), it is expected to fall to 292,000 persons in 2020.
//2007//

/2008/
All population estimates are from DHSS Population MICA and the Census Bureau (http://www.dhss.mo.gov/PopulationMICA/, http://www.census.gov/hhes/www/poverty/poverty.html and http://www.census.gov/hhes/www/hlthins/hlthins.html). The size of the cohort under 5 years of age decreased from 10.8% of the State's total population in 1960 to 6.7% in 2005, and is projected to fall to less than 6.5% of the total population by 2020. The 5-13 age group also declined dramatically between 1960 and 2005, falling from 17.1% to 12.1% of the total population, and is projected to decline further to 11.9% of the population. Though the 15-17 age group is larger than it was in 1960, numbering an estimated 250,062 in 2005 (4.3% of the total population), compared to 194,153 in 1960 (4.5% of the total population), it is expected to fall to 241,608 persons in 2020 (3.9% of the total population).
//2008//

/2009/
All population estimates are from DHSS Population MICA and the Census Bureau (http://www.dhss.mo.gov/PopulationMICA/, http://www.census.gov/hhes/www/poverty/poverty.html and http://www.census.gov/hhes/www/hlthins/hlthins.html).

The size of the cohort under 5 years of age decreased from 10.8% of the State's total population in 1960 to 6.6% in 2006, and is projected to fall to less than 6.5% of the total population by 2020. The 5-13 age group also declined dramatically between 1960 and 2006, falling from 17.1% to 12.0% of the total population, and is projected to decline further to 11.9% of the population. Though the 15-17 age group is larger than it was in 1960, numbering an estimated 255,175 in 2006 (4.4% of the total population), compared to 194,153 in 1960 (4.5% of the total population), it is expected to fall to 241,608 persons in 2020 (3.9% of the total population).
//2009//

/2010/
All population estimates are from DHSS Population MICA and the Census Bureau (http://www.dhss.mo.gov/PopulationMICA/, http://www.census.gov/hhes/www/poverty/poverty.html and http://www.census.gov/hhes/www/hlthins/hlthins.html).

The size of the cohort under 5 years of age decreased from 10.8% of the State's total population in 1960 to 6.7% in 2007, and is projected to fall to 6.5% of the total population by 2020. The 5-14 age group also declined dramatically between 1960 and 2007, falling from 18.5% to 13.2% of the total population, and is projected to decline further to 12.8% of the population. Though the 15-17 age group is larger than it was in 1960, numbering an estimated 255,602 in 2007 (4.3% of the total population), compared to 194,153 in 1960 (4.5% of the total population), it is expected to fall to 241,608 persons in 2020 (3.9% of the total population).
//2010//

In 2002, the percentage of population below poverty level was 9.9%. In 2002, the percentage of school-age children below poverty level was 15.3%.

/2008/
In 2005, the percentage of population below poverty level was estimated to be 11.6% (±2.0%). In 2005, the percentage of children under 18 years of age below poverty level was 17.7% (±4.3%).
//2008//

/2009/
In 2006, the percentage of population below poverty level was estimated to be 12.3% (±2.0%). In 2006, the percentage of children under 18 years of age below poverty level was 16.9% (±5.0%).
//2009//

/2010/
In 2007, percentage of population below poverty level was estimated to be 13.0%. In 2007, percentage of children under 18 years of age below poverty level was 17.7%.
//2010//

In 2000, the percent of children under 18 in Missouri that had limited English language proficiency was approximately 0.6% of the total population under age 18. Geographically, children with limited English language proficiency are situated along the I-70 corridor, around Kansas City and St. Louis and in extreme Southwest Missouri.

A.2. CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

Missouri participated in the first National Survey of Children with Special Health Care Needs that was conducted as a module of SLAITS. Based upon this survey, there are an estimated 215,818(15%) children in Missouri that have special health care needs.

Information from SLAITS Summary Tables from the National Survey of Children with Special Health Care Needs, 2001, shows the national average percentage of:
-CSHCN with adequate health insurance coverage was 59.6 while Missouri's was 66.0;
-CSHCN who receive ongoing, comprehensive care within a medical home was 52.6 while Missouri's was 55.7.

In addition, the national percent of CSHCN needing specific health services:
-for prescription medicine was 87.9 while Missouri's was 90.6;
-for Dental Care was 78.2 while Missouri's was 78.8;-for prevention care was 74.4 while Missouri's was 72.0;
-for specialist care was 51.0 while Missouri's was 52.4;

-for eyeglasses/vision care was 35.6 while Missouri's was 37.1; and
-for mental health care was 25.4 while Missouri's was 28.9.

/2009/
Based on National Survey of Children with Special Health Care Needs (NSCSHCN) 2005-06, there were an estimated 223,070 (16.2%) children in Missouri that have special health care needs. Percentage of CSHCN with health insurance coverage at time of survey was 96.9% in Missouri, similar to the national figure of 96.5%. Among those currently insured, percentage with adequate health insurance coverage was 69% in Missouri, compared with 66.9% nationwide. Percentage of CSHCN who received coordinated, ongoing, comprehensive care within a medical home was 51.8%, slightly higher than nationwide (47.1%).

In addition, national percent of CSHCN needing specific health services:
-for prescription medicine was 86.4 while Missouri's was 87.6;
-for routine preventive care was 77.9 while Missouri's was 75.8;
-for preventive dental care was 81.1 while Missouri's was 80.6;
-for specialist care was 51.8 while Missouri's was 51;
-for eyeglasses/vision care was 33.3 while Missouri's was 33.2; and
-for mental health care was 25 while Missouri's was 25.9.
//2009//

Like CSHCN services most commonly reported in other states as NEEDED but NOT received, Missouri reported dental care, mental health care and specialist care as needed but not received. The charts and tables with these details are available in 3.3.3. Children with Special Health Care Needs of the Needs Assessment along with more charts and tables.

A.3. MIGRATION PATTERNS

An assessment of Missouri's migration patterns by CHIME revealed the following findings (see maps in 3.1.4. Migration Patterns of the Needs Assessment):

"Missouri's population increased by 478,138 persons (9.3%) during the 1990-2000 decade …….More than double the growth of the 1980's (200,307). This was the largest increase, both in terms of actual persons and percentage growth, in the past 70 years. However, Missouri was below the national population increase of 13.2% and ranked 30th among all states in terms of percentage increase. Of particular note, was the dramatic change in migration during the 1990-2000 time period. The net migration increase of 258,458 persons was far greater than anything Missouri had experienced in the recent past. Missouri had been at the break-even level of suffered net-migration losses of greater than 100,000 persons every decade going back to the 1930s. The large changes in migration during the decade of the 1990s fueled the doubling of Missouri's population growth rate. As geographical shifts in Missouri's population were analyzed for this assessment, it is clear that the composition of Missouri's population is increasingly more diverse. Minorities drove much of Missouri's population growth in the nineties and early part of the new century. 'Between 1990 and 2000, the proportion of Hispanics and other persons of color in this state grew from 13.1 percent to 16.2 percent to reach a total of 908,737 Missourians.' Missouri's minority residents now account for fully half of this state's population growth over the last decade. The Hispanic population in Missouri nearly doubled during the last decade, as that minority population grew from 61,702 residents in 1990 to 118,592 in 2000. In summary, Missouri's population (including all MCH population groups) increased by relatively large amounts during the past ten years with the rate of growth slowing during the economic recession beginning in 2000. In absolute terms, Missouri had the highest population increase of the past 50 years. In terms of percentage growth, Missouri migration matched the high water marks of the 1950s and 1960s. The difference between the 1950s era growth was that for the former decade, growth was bolstered by high birth rates; for the latter, it was the result of much higher migration totals. At the county level, Missouri had many fewer counties lose population through migration this decade, compared to the 1980s. However...the Kansas City and St. Louis metropolitan areas, the older

central segments (Jackson County, St. Louis County and St. Louis City) all suffered losses in terms of net migration, while many of the suburban counties surrounding them had relatively high in-migration rates..."

A.4. NEEDS ASSESSMENT METHODOLOGY

The State's overall needs assessment methodology included but was not limited to the following methods:

-Review of Missouri state profiles compiled by Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC) and Association for Maternal and Child Health Programs (AMCHP) to ascertain external perspectives of MCH needs in Missouri
-Qualitative primary data generated through 12 focus groups conducted throughout Missouri divided into two cohorts: client (user) group cohort and provider or agency group cohort
-Review of Community Health Technical Assistance, Resources and Training (CHART) survey of local coalition members, state and county profiles (with selected MCH indicators and related priorities) generated by the Center for Health Information Management and Evaluation (CHIME) and local public health priorities formulated by the Center for Local Public Health Services (CLPHS)
-MCH population group(s) forecasts developed from demographic data drawn from the U.S. Census and from analysis provided by the Missouri State Demographer's Office
-Composite analysis of selected MCH indicators to compare (county by county) the relative MCH health status of women and children living in different geographical regions in Missouri: infant mortality, unintended pregnancies (teenage pregnancies), tobacco use among mothers during pregnancy, STDs among women of childbearing age, abortions, obesity, percentage of MCH population groups with insurance coverage
-Data provided by the Missouri Department of Social Services (DSS), Missouri Department of Mental Health (DMH), Missouri Primary Care Association (MPCA) and other professional associations concerning the infrastructure capacity (in Missouri) to deliver basic health services to MCH population groups
-Nominal group process used by selected MCH stakeholders to suggest possible MCH priorities for Missouri where stakeholders reviewed a draft version of the assessment presented in this application, reflected upon their own experiences and applied the following criteria in delineating MCH priority need areas for Missouri:
Criterion 1--Degree to which need can be impacted by known effective interventions
Criterion 2--Degree of health-related consequence(s) of not addressing need
Criterion 3--Degree of state and national support other than Title V for impacting need
Criterion 4--Degree of current demographic disparity regarding need (e.g. race, gender, income, place of residence)
Criterion 5--Degree to which other local providers or service consumers identify need as a high MCH priority

The accumulated information and analysis identified the following emerging issues:
-Adequacy of Primary Care -Reduction of Obesity
-Domestic Abuse (Violence Against Women)
-Use/Abuse of Tobacco Among Youth
-Mental Health Services for MCH Populations
-Early Childhood Development and Education
-Cigarette Smoking (Tobacco Use) Among Pregnant Women
-Adequate Dental Health Network Capacity

A.5. MISSOURI MCH PRIORITIES

The priorities for the MCH populations identified by the 2005 Needs Assessment are listed below according to levels of service.

A.5.1. MCH Infrastructure

Support Adequate Early Childhood Development and Education in Missouri-Collaborate to coordinate efforts through a leadership role in an interagency coalition for the purpose of better targeting existing resources for early childhood development and education, identifying gaps in service delivery and infrastructure and pursuing necessary resources to address these identified areas.

Improve the Mental Health Status of MCH Populations in Missouri-Collaborate with state and local partners to transition our state mental health service delivery system to a public health model through a variety of avenues, including our leadership role in a multi-agency Comprehensive Children's Mental Health System planning and implementation process; technical assistance to school communities implementing CDC's School Health Index and transition to use of Coordinated School Health model; and a focus on the prevention aspect of mental health and substance abuse issues, particularly in relation to pregnant women, children and adolescents.

Enhance Environmental Supports and Policy Planning/Development for the Prevention of Chronic Disease-Provide technical assistance and support to local, state and regional initiatives to develop or enhance environmental supports and/or policies aimed at addressing the three primary risk factors for the development of chronic disease: nutrition, physical activity and tobacco use/secondhand smoke. Emphasis will be placed upon environmental supports and policies that focus upon the development of positive lifestyle choices and habits and decrease chronic disease for the next generations.

A.5.2. POPULATION-BASED MCH SERVICES

The thrust of the DHSS new strategic plan is to shift the department's operational focus toward prevention and wellness while supporting programs and initiatives that strive to prevent the worsening of conditions. Every priority identified by the five-year Needs Assessment will be viewed from the prevention prospective. Interventions to address the priorities will take into consideration the need to address prevention at the same time.

Reduce Interpersonal/Domestic Violence Among MCH Populations-Continue to advocate for primary prevention to reduce interpersonal violence, as well as provide technical assistance and resources to local and regional partners to implement primary prevention planning in their respective areas using evidence-based approaches.

Prevent and Reduce Smoking Among Adolescents and Women-Collaborate with statewide partners to reduce the number of women who smoke during pregnancy using evidence-based practice.

Reduce Obesity Among Children, Adolescents and Women-Collaborate with statewide partners to achieve healthy weight among an increased percentage of children and adolescents through increased physical activity and healthy eating habits.

Reduce Disparities in Birth Outcomes-Collaborate with state and national partners to examine the intransigent causes and correlations to poor birth outcomes to allow focused interventions and initiatives. Implement and evaluate these resultant interventions and initiatives to decrease racial/ethnic, geographical and socioeconomic disparities related to low birth weight, prematurity, prenatal care received and infant mortality.

Reduce Intentional and Unintentional Injuries among Infants, Children and Adolescents in Missouri-Collaborate with statewide partners to implement environmental supports and local, regional and state policies to positively impact motor vehicle accidents/deaths among adolescents; suicide attempts/completions among adolescents; and intentional/unintentional injuries among infants and children.

A.5.3. DIRECT/ENABLING MCH SERVICES

Improve Access to Care-Provide technical assistance and resources in collaboration with other statewide partners to assure adequacy and cultural competency of provider networks which support reproductive health, primary health, oral health and mental health/substance abuse services for women, infants/children, adolescents and special health care need populations, with an emphasis on medical/oral health home.

Reduce and Prevent Oral Health Conditions Among MCH Populations in Missouri-Collaborate with statewide partners to identify and address gaps in oral health service delivery system; conduct oral health surveillance to inform the oral health systems enhancement initiatives; support the training and placement of oral health professionals in underserved areas to better meet the oral health needs of MCH populations in Missouri; encourage the integration of oral health preventive services into primary care and school health settings.

B. Agency Capacity

B.1. STATE STATUTES

March 29, 1883, Missouri Legislature established state agency responsible for promotion of health and prevention of disease by creating State Board of Health. Missouri Crippled Children's Service (CCS) became part of Division of Health in 1974. Department of Health (DOH) was created 1985 to supervise and manage all public health functions and programs formerly administered by DOH. Executive Order 01-02 in 2001 transferred Division of Aging to DOH and formed Department of Health and Senior Services (DHSS) allowing one department to focus on prevention and quality of life.

Missouri statutes related to MCH and CSHCN authority are primarily in Chapter 191-Health and Welfare and Chapter 201-Crippled Children of Missouri Revised Statutes (RSMo).

Funding appropriated in 2004 allowed dental hygienists to bill Medicaid/SCHIP for services rendered under expanded scope of practice per RSMo 332.311 allowing duly registered and currently licensed dental hygienist with at least 3 years of experience, practicing in public health setting, to provide Medicaid eligible children: fluoride treatments, teeth cleaning, sealants without supervision of a dentist.

RSMo Section 630 incorporates Senate Bill 1003 (Child Mental Health Reform Act) to create Comprehensive Children's Mental Health Service System to serve children with emotional and behavioral disturbance problems, developmental disabilities and substance abuse problems. By August 28, 2007, and periodically thereafter, Children's Services Commission shall conduct evaluations of implementation, effectiveness of the system, family satisfaction and progress of achieving outcomes.

/2008/
House Bill 579 in 2007 transferred State Emergency Management Agency from Office of the Adjutant General to Department of Public Safety for deployment of any health care professional licensed, registered or certified in Missouri or any other state and volunteers during emergency declared by Governor. Bill grants volunteers immunity from civil damages for their services. DHSS is allowed to recruit, train and accept services of citizen volunteers to dispense medication in public health emergency.
//2008//

/2009/
In 2007 Missouri Statute 191.317 was amended to approve provision for releasing results of

newborn screening tests to child's health care professional. Before, family permission had to be given.

RSM0 191.331 was amended to expand financial eligibility guidelines for children through age 18 to receive metabolic formula. Any child under age 5 is financially eligible and those children from age 6 through 18 are eligible at 300% of federal poverty level (FPL). DHSS rules to implement this statutory provision provide sliding scale for family incomes exceeding 300% of FPL so no family pays more than 50% of cost of formula. Provision provides DHSS authority to use, retain and dispose of biological specimens in conjunction with newborn screening tests and public health research.
//2009//

/2010/
Any child under age 6 is financially eligible.
//2010//

B.2. CAPACITY AND COLLABORATION

/2007/
August 2005 DHSS made organizational changes for better utilization of resources, viability of services and position to respond to Missouri State Government Review Commission recommendations.

DCPH was created to raise visibility of public health and be more conducive to planning and implementing public health programs and services with common goals.

DCPH is Missouri Title V agency and takes lead responsibility and collaborates with other state agencies, local communities and private organizations in developing, implementing and supporting policies and services to ensure statewide system to provide for pregnant women, mothers, infants, children and CSHCN.

Offices and programs located in DHSS collaborating with other agencies and entities follow. See www.dhss.mo.gov/AboutDHSS/Directory_of_Services.pdf.

B.2.1. DHSS DEPARTMENT DIRECTOR'S OFFICE is responsible for management its programs and services with assistance of departmental deputy director. Divisions reporting to Director include Information Technology Services Division, Departmental Support Services, Division of Senior and Disability Services, Division of Regulation and Licensure, DCPH, Boards of Senior Services and Health.

B.2.2. INFORMATION TECHNOLOGY SERVICES DIVISION (ITSD) of the State Office of Administration maintains and enhances an integrated Oracle database that houses client and provider data for MCH applications in DHSS. An interface with DSS provides access to Medicaid eligibility information for DHSS clients. Provider payments are made via interface with Missouri's state accounting system.

B.2.3. DIVISION OF REGULATION AND LICENSURE (DRL), Section for Health Standards and Licensure (HSL), supervises health care and child care licensure activities, state emergency medical services (EMS), registration of Missouri handlers of controlled substances and inspection activities for many Medicare certification programs.

Bureau of Child Care (BCC) is responsible for licensing of family and group child care homes and child daycare centers, staff qualifications and quality initiatives (inclusion services, Nurse Consultation, etc.).

Title V Block Grant funds enhance Child Care Resource and Referral (CCR&R) services for

families and CSHCN to provide services including referrals of families to child care programs. Referral Specialists collect data (immunizations, diseases, birth defects, developmental issues and insurance status, etc.).

/2008/
BCC was elevated to Section for Child Care Regulation (SCCR) within DRL.
//2008//

/2009/
Child Care Health Consultation (CCHC) program moved from SCCR to CLPHS in Center for Health Policy Integration (CHPI) of DCPH in August 2007.

CCHC is collaborative project of DHSS and local health agencies. It is partially funded by MCH Title V (2007 7.36%; 2008 11.48%, CCHC). Among other duties, CCHC assists families and child care providers in accessing needed health and social service programs to: decrease risk of injury, disease and abuse of children; provide education and consultation for families of children enrolled in child care facility. Consultation, group training and health promotion addressed asthma, CSHCN, nutrition and physical exercise/fitness, health care access, injury prevention and safety, diabetes, second-hand smoke, chronic disease, dental health, mental health, SIDS and ADHD.
//2009//

/2010/
CCHC program reported increase in number of child care facilities served (2,824) and children impacted (79,531) in 2008.
//2010//

B.2.4. DCPH administers programs addressing chronic disease prevention and nutrition services, healthy families and youth, community protection and provides public health practice and administrative support.

/2009/
Centers and offices reporting directly to DCPH are:
-Center for Emergency Response and Terrorism (CERT)
-State Public Health Laboratory (SPHL)
-Office of Performance Management
-Office of Financial and Budget Services (OFABS)
-Section for Chronic Disease Prevention and Nutrition Services (CDPNS)
-Section for Healthy Families and Youth (HFY)
-Section for Disease Control and Environmental Epidemiology (DCEE)
-Section of Epidemiology for Public Health Practices (EPHP)
-Center for Health Policy Integration (CHPI)
//2009//

DHSS changes in July 2007 included:
-CERT joined DCPH as DCPH plays large part in emergency preparedness and response.

-SPHL joined DCPH as it works closely with emergency response staff, Department Situation Room and CERT and many disease control, environmental and genetic aspects in DCPH.

EPHP in September 2007 and CHPI were formed in DCPH.

/2008/
B.2.4.1. CERT developed Ready in 3 for easy 3-step way to prepare for emergency; materials including "Planning for Emergencies: Three Steps to be Prepared; A Family Safety Guide":
1. Create plan for you, your family and your business
2. Prepare kit for home, car and work

3. Listen for information about what to do and where to go during actual emergency

B.2.4.2. SPHL serves as support unit to DCPH when performing tests for newborn screening and confirming diagnosis; and works closely with emergency response staff, Department Situation Room and CERT, and many disease control and environmental aspects in DCPH.

B.2.4.3 OFABS, elevated directly under DCPH Director's office, provides leadership and oversight of fiscal management systems; provides fiscal and budgetary expertise for DCPH, ensures process of invoices and contract payments; supports MCH-related contracts and fiscal note preparation; serves as fiscal issues primary contact for DCPH programs and operations; assures fiscal resources contribute to achievement of DCPH's strategic goals.
//2008//

B.2.4.4. CDPNS directs statewide programs designed to combat major causes of premature death, illness, disability and medical costs such as heart disease, cancer, stroke, diabetes, asthma and arthritis through: Bureau of Cancer and Chronic Disease Control (CCDC); Bureau of Health Promotion (BHP); Bureau of Community Food and Nutrition Assistance (CFNA) Programs; and Bureau of WIC and Nutrition Services (WICNS).

B.2.4.4.1. CCDC is to reduce impact of chronic disease by promoting screening and early detection of chronic diseases and evidence-based management with focus on arthritis, asthma, heart and stroke, diabetes and cancer.

B.2.4.4.2. BHP oversees programs and initiatives to reduce tobacco use, physical inactivity and unhealthy eating and supports local programs through contracts, training and technical assistance in implementing evidence-based strategies to reduce risk factors.

/2008/
Governor's Council on Physical Fitness and Health strives to promote a healthy Missouri where people are making healthy lifestyle choices. Council oversees Shape Up Missouri/Moving Across America State by State, Show-Me Body Walk and Show-Me State Games, etc.
//2008//

B.2.4.4.3. WICNS's focus is to decrease preventable nutrition-related morbidity and mortality. Programs coordinated by WICNS focus on assuring "nutritionally at-risk" Missourians receive nutritious food supplements through local grocery vendors.

B.2.4.4.4. CFNA is dedicated to enhancing nutritional status of vulnerable Missourians by ensuring nutritious meals and snacks are served and good eating habits are taught to eligible participants (primarily children, pregnant and breastfeeding women not enrolled in Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and disabled adults or those over age 60 who meet income-eligible guidelines).

B.2.4.5. HFY manages Genetics and Healthy Childhood (GHC) and Special Health Care Needs (SHCN). HFY promotes optimal health by providing leadership to public and private sectors in assessing health care needs of families and communities; develops policy, plans systems of care and designs, implements and evaluates programs to meet health care needs of families.

B.2.4.5.1. GHC promotes and protects health and safety of individuals and families based on their unique needs and situations and utilizes multiple programs in GHC to optimize individual's health and environment from pre-pregnancy through adulthood. Programs include Genetic Services, Newborn Blood Spot Screening, Missouri Newborn Hearing Screening (MNHSP), Newborn Health, Breastfeeding, Birth Defects Awareness, Home Visitation, Alternatives to Abortion, Fetal and Infant Mortality Review (FIMR), Pregnancy Associated Mortality Review (PAMR), Adolescent Health, School Health, Injury/Violence Prevention, Missouri Fetal Alcohol Syndrome Rural Awareness and Prevention Project (MOFASRAPP) and Alcohol, Tobacco and Other Drug

Prevention and Awareness (ATODPA).

/2009/
And Teleheath Medicine; however MOFASRAPP portions expire 9/29/08.
//2009//

/2010/
One portion of MOFASRAPP grant, the FAS Clinic at UM is being funded until 9/29/09.
//2010//

GHC Cultural Competence:

Printed materials purchased in Spanish and, when available, in Vietnamese and Chinese for MOFASRAPP and Missouri Model for Brief Smoking Cessation Training.

MOFASRAPP development included focus groups with racial and ethnic groups of women in 71 targeted counties.

MOFASRAPP flyers and radio advertising depict rural African-American, Hispanic and Caucasian women.

MOFASRAPP utilizes UMC toll-free number for two of its interventions; interpretive services are arranged for callers with limited English proficiency.

/2009/
MOFASRAPP portion for 3 preceding activities expires 9/29/08.
//2009//

/2010/
One portion of MOFASRAPP grant, the FAS Clinic at UM is being funded until 9/29/09.
//2010//

Missouri Model for Brief Smoking Cessation Training includes cultural counseling suggestions for African-American, American Indian, Asian American and Pacific Islander, Caucasian and Hispanic female populations.

/2009/
Funding for Missouri Model Training ends 12-31-08.
//2009//

/2010/
Missouri Model Training offered as requested for providers through FY2009 using MCHBG.
//2010//

Abstinence and Teen Outreach Program (TOP) contractors are required to report race and age of clients served. Adults and youth delivering programs must represent youth, communities and neighborhoods served.

Council for Adolescent and School Health (CASH) is composed of adolescent and school health experts representing diverse ethnic backgrounds and geographic areas including rural and urban cultures and communities.

Missouri Community-Based Home Visiting (MCBHV) program requires staff "that reflect the ethnic, cultural and social characteristics of the community served". MCBHV in Columbia serves Hispanic population with Hispanic workers who speak English and Spanish.

Building Blocks programs in Kansas City and St. Louis have bilingual home visiting nurses to serve Hispanic population; interpreters go on visits or staff use "Language Line" when clients are of other nationalities.

Home visiting programs' databases collect race and nationality data of all clients served and collaborate with local area programs (Parents as Teachers [PAT], WIC, prenatal case management, HUD, food pantries, etc.) that provide services to high-risk population.

/2009/
Home visiting and domestic violence programs hosted domestic violence seminar July 2007 to educate providers of home visiting and Alternatives to Abortion programs on domestic violence. Program was funded by grant for Healthy and Safe Families through AMCHP and included cultural competency issues dealing with domestic violence victims.

GHC hosted Health Literacy workshop in September 2007 for HFY staff and contractors of home visiting and Alternatives to Abortion programs to promote cultural competency and health literacy in choosing educational materials for program promotions.
//2009//

/2010/
The School Health Program includes speakers on cultural competency at school nurse conference.
//2010//

FIMR projects have community members (area physicians, social workers, members of the religious sect, local health departments, etc.) on both Case Review and Community Action Teams.

Newborn Health, Baby Your Baby and Folic Acid initiatives provide educational materials in English and Spanish including 2005 revised Baby Your Baby Keepsake Book.

Missouri Newborn Hearing Screening Program (MNHSP) provides parent informational brochures in English, Spanish, Croatian and Vietnamese. Informational flyers on hearing loss and risk factors for late-onset hearing loss are printed in English and Spanish. Regional Representatives (RRs) utilize Language Link as needed for interpretive services during phone calls to families. RRs have been trained to say, "Please wait while I get a translator," in Spanish. MNHSP program manager participated in cultural competency training for individuals and organizations.

/2008/
MNHSP staff participated in CDC-sponsored teleconference on cultural competency.
//2008//

/2010/
MNHSP provides parent informational brochures in English, Spanish, Bosnian and Vietnamese. Informational flyers on hearing loss and risk factors for late-onset hearing loss in English and Spanish. RRs utilize Language Link for interpretive services during phone calls to families. RRs have been trained to say, "Please wait while I get a translator," in Spanish.
//2010//

Missouri Blood Spot Screening Program provides patient information brochures in Spanish, Bosnian and Vietnamese.

Minority health issues for Genetic Tertiary Centers are foremost concern since genetic diseases often cluster in specific ethnic groups. Availability of foreign language and deaf interpreters, acceptance of Medicaid and Medicare as full payment for services and sensitivity by genetics

staff to minority and handicapping health issues promote delivery of genetic services for Missourians who are part of minority groups. During FFY 2006 programs will be aimed toward Hispanic and Mennonite populations.

GHC Programs:

Four genetic tertiary centers (St. Louis Children's Hospital, Cardinal Glennon Hospital for Children, Children's Mercy Hospital and University of Missouri Hospital and Clinics) collaborate with DMH-Division of Mental Retardation and Developmental Disabilities (MR/DD); DSS-Division of Medical Services (DMS) that administers the Medicaid program; DSS-Family Support Division; Department of Elementary and Secondary Education (DESE)-First Steps; DHSS-SHCN and Metabolic Formula Program. Centers also collaborate with national organizations such as Association of Retarded Citizens (Arc) and refer to local parent support groups (fragile X syndrome, Downs Syndrome, etc.).

/2009/
DMS is now MO HealthNet Division (MHD) and is responsible for: administration of services provided in accordance with Title XIX, Public Law 89-97, 1965 amendments to federal Social Security Act, 42 U.S.C. Section 301, and purchase and monitoring health care services for low income and vulnerable citizens.

Telehealth Medicine program provides genetic clients in southern Missouri option of being seen in location close to home.

Metabolic Formula Program, funded by general revenue, provides assistance to individuals of all ages diagnosed with covered metabolic condition and meet financial eligibility criteria. It works with formula manufacturers, retail pharmacies, MO HealthNet and genetic tertiary centers to assure program participants are covered.

Missouri Sickle Cell Anemia Program promotes and provides education, screening, counseling and follow-up services for individuals with sickle cell disease and sickle cell trait.
//2009//

/2010/
Telehealth Medicine program expanded to provide services to patients with autism spectrum disorders.

On October 16, 2008 Governor Matt Blunt signed an executive order officially changing the name of the MR/DD to the DD.
//2010//

DHSS contracts with 5 resource centers (Children's Mercy Hospital, University of Missouri Hospital, St. Louis Children's Hospital, Barnes Hospital and Truman Medical Center) to ensure availability of comprehensive medical services for individuals and families with sickle cell conditions. Contractors are required to have information and education materials available in variety of culturally competent formats and provide other services, including foreign language translators and interpreters for hearing impaired. DHSS also collaborates with local agencies, provider groups, coalitions and community-based sickle cell organizations that provide supportive services to individuals and families for non-medical needs.

Newborn Blood Spot Screening Program provides early identification and follow-up of PKU, galactosemia, congenital hypothyroidism, congenital adrenal hyperplasia, hemoglobinopathies, amino acid disorders, fatty acid oxidation disorders and organic acid disorders (cystic fibrosis [CF] and biotinidase to be added early 2007) that suggest presence of disease in affected, but as yet, asymptomatic infants to ensure a repeat newborn screen or confirmatory test has been done. Infants found to be positive are referred to health care system.

/2008/
CF will be added in mid 2007; biotinidase in FFY 08.
//2008//

/2009/
2007 CF was added. Biotinidase deficiency is expected late 2008. When added, Missouri will be screening for all 29 conditions recommended by American College of Medical Genetics and March of Dimes.
//2009//

/2010/
Newborn blood spot screening provides early identification of certain genetic and endocrine disorders that suggests the presence of disease asymptomatic infants to ensure repeat newborn screen or confirmatory test are done and infants found positive are referred to a system of health care. With the addition of adding CF in 2007 and biotinidase deficiency in 2008, Missouri screens for all 29 core conditions recommended by the American College of Medical Genetics and the March of Dimes. When considering secondary conditions, screening for these disorders actually allows for a total of 67 disorders to be detected.
//2010//

MNHSP ensures all babies born in Missouri receive hearing screen and appropriate follow-up including audiologic diagnostic testing and referral to Part C services; most are screened prior to hospital discharge.

Folic Acid Program coordinates Missouri Folic Acid Advisory Committee activities to further enhance awareness of folic acid benefits in preventing neural tube defects and other serious birth defects.

/2009/
2008 the Newborn Health program will use funding from March of Dimes, Missouri Chapter, to work with University of Missouri (UM), Sinclair School of Nursing and high schools in central Missouri to educate students in consumer health sciences classes on benefits of taking folic acid. Before, program had been implemented in northwest Missouri by Missouri Western University. DHSS collaborating with UM hopes to replicate the program.
//2009//

/2010/
2008 March of Dimes, Missouri Chapter, funding has been extended until June 30, 2009, to complete data analysis and reporting of pre, post and follow-up test results from implementation of folic acid educational programs in 15 central Missouri high schools in collaboration with UM, Sinclair School of Nursing. This funding will also be used to support DHSS epidemiological research for the March of Dimes, Missouri Chapter.
//2010//

Breastfeeding Program promotes and supports breastfeeding to improve health of infants and their mothers and provides technical assistance, training and educational materials to health providers and general public on breastfeeding and nutritional supplementation appropriate for infants.

Home visiting programs provide services to high-risk pregnant women and their infants prenatally through age 2. Registered nurses (RNs) provide health assessments for prenatal and postpartum mothers and their newborns, while RNs and family support workers provide assessment of risk factors associated with child abuse and neglect; education on maternal/infant/child health, nutrition and parenting; parenting and family support; and case management with appropriate

referrals. Building Blocks of Missouri program has sites in Kansas City, Southeast Missouri, St. Louis and Springfield regions and uses Nurse Family Partnership model developed by Dr. David Olds. MCBHV utilizes Families at Risk model developed by UMC/Sinclair School of Nursing in collaboration with DHSS and serves families in 13 counties through contracts with LPHAs and community-based organizations.

/2009/
Springfield site was discontinued July 2007; it had been funded for 4 years by a Healthy Communities, Healthy School grant that ended.
//2009//

/2010/
Serves families in 12 counties.
//2010//

ATODPA targets prevention and/or reduction of incidence of alcohol, tobacco and other drugs in preconceptional and prenatal periods, impacting health of maternal and child populations. It includes educational outreach with UMC in use of Missouri Model for Brief Smoking Cessation Training and CDC-funded grant titled MOFASRAPP, a collaboration of DHSS, UMC, DMH, St. Louis Arc and Missouri Institute of Mental Health.

/2008/
ATODPA continues educational outreach with cessation training and CDC-funded MOFASRAPP.
//2008//

/2009/
MOFASRAPP grant expires 9/29/08. GHC is requesting no-cost extension to continue surveillance portion of grant. Depending on available funding and interest of UMC, FAS Clinic may also continue until 9/29/09.

Missouri Model training is no longer through UMC contract.

Through December 2008, five 60-90 minute Missouri Model for Brief Smoking Cessation Training presentations are being offered to health care providers of different disciplines who work with women of reproductive age.
//2009//

/2010/
Missouri Model Training will be offered as requested for providers through FY2009 using MCHBG funding.
//2010//

Currently implemented in St. Louis and Kansas City, FIMR analyzes infant and fetal death records to develop recommendations for community change to reduce fetal and infant mortality. Communities then determine and implement interventions based upon recommendations received that may improve outcomes for future families.

/2010/
GHC and OOE to do an evaluation of all FIMR cases in Kansas City and St. Louis that have been abstracted from inception through September 30, 2008.
//2010//

In PAMR study, weight gain information was gathered on all women studied and BMI determined. Evaluation of PAMR data may lead to better understanding and ability to develop interventions.

Adolescent Health Program collaborates with DHSS programs, state and community partners.

CASH advises DHSS in assessing adolescent health needs and planning effective strategies to reduce health risks and promote healthy youth development. It contracts for adolescent medicine consultation and educational programs for health professionals, school personnel, parents, adolescents, state agencies and community organizations. Contracts with LPHAs and Wyman Center support / to implement best practices for healthy youth development.

Federal State Title V, Section 510 funding supports contracts with school, community and faith-based organizations to implement abstinence education and youth development programs for adolescents and parent-child sexuality education programs.

School Health Program began as joint effort of DHSS, DESE and DSS to promote enrollment in Medicaid and increase utilization of Healthy Children and Youth (HCY, Missouri's federal Early and Periodic Screening, Diagnosis and Treatment [EPSDT] program for persons under 21) for preventive health services. Effort is made to assure adequate nurse-to-student ratio. Technical assistance and consultation are available.

Injury and Violence Prevention Programs develop public policy, coordinate interventions, collaborate with other agencies addressing injury causes, support collection and analysis of injury data and contracts with community agencies for violence against women (VAW) prevention interventions linked to State VAW Plan.

/2009/
March 2008 GHC began toll-free 24/7 Alternatives to Abortion Information and Referral Line to provide information on Alternatives to Abortion providers. Line provides immediate translation into Spanish and connection to language line for other languages.
//2009//

B.2.4.5.2. SHCN develops, promotes and supports community-based systems that enable best possible health and highest level of independence for Missourians with special health needs.

SHCN utilizes combination of state and federal funds to provide services for children and adults with disabilities, chronic illnesses and birth defects. Services include assessment, treatment and service coordination. Activities of SHCN are focused around National Performance Measures and 6 Key Systems Outcomes of Division of Services for Children with Special Health Needs (DSCSHN), MCHB, HRSA, U.S. Department of Health and Human Services (DHHS).

/2009/
SHCN developed Service Coordination Model, http://www.dhss.mo.gov/SHCNpdfs/SCModel.pdf)
//2009//

SHCN Cultural Competency:

SHCN contracted with UMKC, Institute for Human Development, to provide professional training to increase cultural-competency of SHCN staff and providers. Hispanic families with CSHCN or other disabilities were identified to assist with training. Institute supplied Spanish translation on several SHCN documents. SHCN continues to monitor changing demographics and address translation of SHCN letters and forms utilized by non-English speaking participants/families.

/2008/
UMKC contract was fulfilled. SHCN staff participate in events focused to increase knowledge and awareness of cultural diversity.
//2008//

/2009/
Service Coordinators and SHCN staff members participate in activities to increase knowledge and awareness of cultural diversity including American Indian Council Symposium, West Central

Multicultural Forum, Ozark Regional Alliance, Cross Cultural Interpreter Training and Vietnamese American Health Fair. SHCN monies fund language line services and interpreters for Service Coordinators to communicate with individuals with limited English.
//2009//

/2010/
SCs and SHCN staff members participate in activities to increase knowledge and awareness of cultural diversity including the American Indian Council Symposium, Health Care Quality Forum, West Central Multicultural Forum, Cultural Sensitivity Classes, Vietnamese American Community Committee, and the Kansas City Minority Health Commission. SHCN had the Annual Financial Review Forms translated into 8 languages to better serve individuals with limited English proficiency.
//2010//

SHCN Programs:

Administrative Case Management (ACM) for HCY and Missouri Medicaid Physical Disabilities Waiver/ACM provide home and community-based services to limited number of individuals 21 and older with serious and complex medical needs.

CSHCN-Hope Program (RSMo, CCS) is administered through SHCN to provide early identification and health services from participants' birth to 21.

Service Coordination provides for participants/families to receive services from individuals located within participant's region through Service Coordinators' (SCs) use of:
-Comprehensive Assessment Tools (CATs, standardized means to assist in identification of participant/family needs; services necessary to transition through all aspects of life)
-Medical Home [MH])
-Service Plans developed with participants/families
to achieve best possible health and highest level of independence for SHCN participants.

Transition Plans completed by SCs with participants/families and team members (health care professionals, school personnel, state or community agencies, etc.) address participants' needs.

/2008/
CATs include all 6 key system outcomes identified by MCHB/DSCSHN.
//2008//

/2010/
The CAT was replaced with the SCA. The SCA is web-based and is more efficient in supporting the identification of needs and services.
//2010//

With external entities, SHCN collaborates to:
-increase organization of community-based service systems;
-link with DMS for participants' current Medicaid status;

and/or contracts for:
-assistive technology for eligible CSHCN from birth to 21;
-State Disability Determination Unit (DDU) to refer children applying for SSI to CSHCN program;
-UMKC, Institute for Human Development, to coordinate statewide, multi-agency efforts for HRSA/MCHB grant for Missouri's Early Childhood Comprehensive System (ECCS) Plan;
-participation in local, regional and state disaster response planning activities to represent SHCN participants' needs.

Family Partnership (FP) Initiative is implemented through contract for statewide activities and

provides families of individuals with special needs with opportunity to: offer each other support and information; give SHCN input; increase public and community awareness of special needs issues; and promote state legislation for programs for individuals with special needs and their families.

Collaborative efforts with an LPHA in Southwest Missouri and with Reynolds County Health Center are to improve services for special needs children and increase utilization and understanding by engaging and training key stakeholders in MH concept.

/2008/
LPHA MH contracts have been fulfilled. SHCN continues to distribute MH concept materials.
//2008//

SHCN Adult Head Injury Program facilitates Missouri Head Injury Advisory Council (MHIAC) which makes recommendations for improvement of systems to meet needs of those with traumatic brain injury (TBI) and serves in advisory role to Federal TBI Implementation Grant awarded to DHSS.

SHCN continues to recruit additional providers to improve availability of services to participants; utilizes GIS mapping to identify areas of need for participants and providers; places SHCN provider enrollment forms on Internet; maintains provider enrollment information in the Missouri Health Strategic Architecture and Information Cooperative (MOHSAIC) system for access by SCs.

/2009/
B.2.4.6. EPHP was created to combine State Epidemiologist, Office of Epidemiology (OOE), Office of Community Health Information (CHI), Bureau of Health Informatics (BHI), and Bureau of Vital Records (BVR).

EPHP serves as highest scientific authority on issues related to control and prevention of diseases and health risk behaviors. EPHP houses resources necessary to operate and maintain major public health information systems, state vital statistics, state vital records, community health information, major federal block grants, contracts supporting public health surveillance and medical and public health epidemiology resources necessary to prevent, intervene and control infectious disease and other conditions impacting Missourians' health.
//2009//

B.2.4.6.1. OFFICE OF EPIDEMIOLOGY (OOE) (a merger of OOE with Grants Development to consolidate resources mutually beneficial) provides epidemiologic leadership, consultation and expertise for DHSS divisions and centers, LPHAs, other stakeholders and partners to enhance health and safety of Missouri citizens; guides public health practices through effective use of public health surveillance; plans and evaluates public health programs; provides epidemiologic and medical consultation; conducts epidemiologic teaching and training; plays leadership role in setting state health policy; and provides grant development and management of MCH and Preventive Health and Health Services block grants and State Systems Development Initiative grant; designs/supports continuous quality improvement teams to improve outcomes and reduce operational costs, evaluations of community health programs, statewide need/capacity assessments, contracts and memorandums of understanding required for major surveillance systems managed by DHSS.

Some projects OOE plays lead role: State Infant Mortality Collaborative; Perinatal Period of Risk Approach (PPOR) analyses; Missouri Pregnancy Risk Assessment (MoPRA), a Pregnancy Risk Assessment Monitoring System (PRAMS)-like survey and application for PRAMS funding; Fetal Alcohol Syndrome surveillance; autism surveillance; surveillance of TBI among children and adolescents and application for research funding; design and implementation of methodology to determine new state priorities; MCH research agenda for Missouri; investigations of perceived

clusters of adverse MCH events; and evaluation of several MCH programs.

/2009/
MoPRA evolved into PRAMS. Toddlers survey is being considered.
//2009//

B.2.4.6.2. CHI is responsible for promoting health information for DCPH and TEL-LINK, (800) 835-5465, DHSS toll-free information and referral telephone line for maternal, child and family health services. Staff serves as integral part of preventive health care programs such as smoking cessation, cancer detection, treatment and management of obesity programs, genetics and child nutrition assistance services.

B.2.4.6.3. BHI is responsible for vital statistics system; maintains various health-related databases; performs linkages between program and vital statistics data; provides program evaluations based on applicable program-vital statistics data; provides Internet access to MCH indicators via Community Data Profile pages and MICA system; collaborates with such entities as DMS [now MO HealthNet] regarding MCH indicators for Medicaid managed-care population; provides support for Missouri Child Fatality Review program; produces health indicators from linked birth-PAS data systems; links Statewide Traffic Accident Records Systems (STARS) motor vehicle crash data to hospital inpatient and emergency room data and death certificate data to study medical and cost outcomes of crashes; and provides data support to private organizations such as March of Dimes.

Vital Statistics system follows National Center for Health Statistics (NCHS) guidelines regarding collection and analysis of race and ethnicity data.

BHI has a diverse staff that includes individuals from foreign countries that speak different languages.

B.2.4.6.4. Bureau of Vital Records fulfills DHSS's statutory responsibility to serve as state archives for vital records; and maintains central registry of births, deaths and fetal deaths and Putative Father Registry; maintains reports of marriages and divorces; conducts trainings to ensure accurate and timely filing of vital records; and provides vital records for use in preparation and publication of vital statistics data for national, state and local levels.

/2009/
B.2.4.7. CHPI was established for increased integration, collaboration among DCPH, DHSS and external partners with focus on policy and legislative issues and rules. CHPI has Center for Local Public Health Services (CLPHS), Office of Minority Health (OMH), Office of Primary Care and Rural Health (OPCRH) and Office on Women's Health (OWH).
//2009//

/2010/
CHPI tracking Performance Management activities.
//2010//

B.2.4.7.1. CLPHS includes MCH Coordinated Systems and adds value to state public health system by supporting population-based approach to health issues in communities and provides leadership and technical assistance to LPHAs to help develop processes to improve community-based public health systems.

/2009/
CCHC program moved from SCCR to CLPHS in CHPI August 2007.

FFY 2007, 112 of 114 counties were provided free services of health consultation, education and health promotion through CCHC program.

2,482 child care facilities impacting 74,484 children received services. Health Issues of Obesity Prevention and Asthma Management in the young child were specifically targeted.

Structured education was provided to child care providers and parents on related topics. 1,827 completed education on "Healthy Nutritional Environment"; 1,472 on "Healthy Environment around Physical Activity; 1,917 on Asthma Management in Young Children.

FFY 2008 has same targeted issues with additional educational components offered for Obesity Prevention and 1:1 consultation offered on development of individual asthma action plans in child care. 112 of 114 Counties in Missouri are receiving these services.
//2009//

/2010/
FFY 2008, 110/114 counties were provided CCHC services. 2,824 child care facilities impacting 79,531 children received services. Targeted Health Issues "Obesity Prevention" and "Asthma Management"

Targeted Health Issues in 2009 expanded to include education around the inclusion of all cyshcn in child care and the development of IHAPs for cyshcn in the child care setting. 112/114 counties in Missouri are receiving CCHC services.
//2010//

MCH Coordinated Systems distributes federal MCH Services Block Grant funds to LPHAs through its MCH services contract to maintain and improve health status of maternal and child populations by establishing and maintaining integrated multi-tiered service coordination system with capability of adapting to address targeted MCH issues. Each contractor has contractual obligation to utilize evidence-based interventions and address identified MCH risk indicators most disparate from state rates.

In FFY 2005 there were 110 LPHA contracts with community specific interventions with over 265 short-term outcomes to reach Healthy People 2010 objectives.

/2008/
In FFY 2006 there were 110 LPHA contracts with over 265 short-term outcomes. Under new contracts in 2007, there are 111 contracts with over 150 short term outcomes to reach Healthy People 2010 objectives while addressing Missouri's MCH priorities. New contracts are allowing selection of fewer outcomes for more money to be focused on selected outcomes.
//2008//

/2009/
Under new contracts in 2008, there are 112 contracts with 112 systems building outcomes to reach Healthy People 2010 objectives.
//2009//

/2010/
FFY2009, 113 of the 114 LPHAs have contracts with systems building outcomes with community partners. Priority health issues are injury, obesity and tobacco prevention.
//2010//

B.2.4.7.2. OMH addresses cultural competency; develops and reviews DHSS programs that impact health status of minorities.

/2009/
Initiatives address infant mortality in high risk communities and obesity in children and adults.

May 2008 OMH through agreement with MFH released STATE OF MISSOURI HEALTH DISPARITIES REPORT: PROMOTING HEALTH EQUITY & REDUCING HEALTH DISPARITIES IN MISSOURI. It revealed substantial inequities among ethnic/racial and other vulnerable Missouri groups. OMH held focus groups with minorities to reveal barriers. Report ended with guidelines issued to health care organizations to lessen health disparities occurrence. See Needs Assessment section attachment.
//2009//

B.2.4.7.3. OWH, supported by Title V, exists to integrate awareness of culturally competent women's health issues and concerns into planning for DHSS programs and services, coordinate existing activities related to health of girls and women and promote broader, more effective collaboration related to women's health issues. Top priority areas:
--Violence against women
--Healthy lifestyles
--Protection of families from violence

B.2.4.7.4. OPCRH works to ensure access to and availability of primary health care services for all populations. OPCRH Oral Health Program (OHP) provides broad range of core public health services, including preventive and restorative dental care, oral health surveillance, oral health promotion and education, public water fluoridation monitoring and support, technical assistance to communities and oral health research. It serves as resource on oral health issues for other state and federal agencies, dental professionals, community organizations and the public. Initiatives include Elks Mobile Dental Program, Oral Health Preventive Services Program, Fluoride Mouthrinse (FMR) Program, Oral Health Surveillance, Public Water Fluoridation Program and Preventive Dental Services Program.

/2008/
Also Missouri Donated Dental Services (DDS), Portable Dental Equipment, and Missouri Coalition for Oral Health.
//2008//

/2009/
To enhance educational materials available through OHP, PowerPoint presentations were designed specifically for kindergarten-high school seniors and made available free-of-charge on DHSS Web site in 2007. Presentations can be used by School Nurses, teachers or other healthcare/child care professionals in conjunction with their health curriculum.
//2009//

/2010/
Effective 10/1/09, the Elks Mobile Dental Program discontinued.
//2010//

Dental Advisory Group helps OHP evaluate oral health environment, assists in evaluation of DHSS oral health programming and provides guidance in future public health interventions to decrease oral disease.

OHP employs cadre of Registered Dental Hygienists in communities to aid in development of oral health interventions and act as liaisons with communities, health professionals and schools on oral health issues.

OHP develops new oral health initiatives and update and enhance current program activities in collaboration with dental consultant from UMKC School of Dentistry.

/2009/
OHP is collaborating with Dental Advisory Group to develop new Oral Health Plan to enhance ongoing activities and additional initiatives to improve oral health. Another initiative planned is to

work further with SHCN, MRDD, Elks Mobile Program, LPHAs and Federally Qualified Health Centers (FQHCs) to develop strategies to improve oral health care access for special health care needs population.
//2009//

/2010/
Dental Advisory Group renamed to Oral Health Advisory Group.
//2010//

C. Organizational Structure

DHSS has streamlined Division of Community Health's (DCH) operations to more effectively serve women, infants, children and adolescents in Missouri. DCH is responsible for maternal, child and family health; nutritional health; chronic disease prevention and health promotion; and programs for community health improvement. DCH is also responsible for the preparation of Maternal and Child Health (MCH) Services Block Grant annual plan and application. Director of DCH serves as Director of the state's Title V program, as well as Director of the state's CSHCN program.

/2007/
DCH is now the Division of Community and Public Health (DCPH).
//2007//

Section III. State Overview, B. Agency Capacity, contains more detailed information regarding the sections and programs. The DHSS Web page provides access to the Directory of Services with descriptions for all services of DHSS at http://www.dhss.mo.gov/AboutDHSS/Directory_of_Services.pdf.

Organizational charts for State Executive Departments, DHSS and DCH [DCPH] are located in the attached file to illustrate the hierarchy of the government and the state agencies and are maintained on file.

Other divisions, centers and offices within DHSS which continue to play vital roles in supporting a comprehensive set of services for targeted Title V populations in Missouri are:
-Division of Senior Services and Regulation, Section for Health Standards and Licensure, Bureau of Child Care
-Division of Environmental Health and Communicable Disease Prevention (EHCDP)
-Department/Program Support Services, Center for Health Information Management and Evaluation (CHIME)
-Office of Epidemiology
-Center for Local Public Health Services (CLPHS)
-Office on Women's Health
-Office of Minority Health
-Senior Services
-Division of Administration Services

/2007/
Due to the reorganization, of the above agencies, only Bureau of Child Care of the new Division of Regulation and Licensure and State Office of Administration's Information Technology Services Division (ITSD) (formerly part of CHIME) remain outside of the Division of Community and Public Health.

CHIME databases and information systems are now located within BHI of PHPAS and the State OA ITSD.
//2007//

/2008/
BCC was elevated to a section within DRL and is now Section for Child Care Regulation (SCCR).
//2008//

/2009/
DCPH administers programs addressing chronic disease prevention and nutrition services, healthy families and youth, community protection and provides public health practice and administrative support.

Centers and offices reporting directly to DCPH are:

-Center for Emergency Response and Terrorism (CERT)
-State Public Health Laboratory (SPHL)
-Office of Performance Management
-Office of Financial and Budget Services (OFABS)
-Section for Chronic Disease Prevention and Nutrition Services (CDPNS)
-Section for Healthy Families and Youth (HFY)
-Section for Disease Control and Environmental Epidemiology (DCEE)
-Section of Epidemiology for Public Health Practices (EPHP)
-Center for Health Policy Integration (CHPI)

DHSS changes in July 2007 included:
-CERT joined DCPH as DCPH plays large part in emergency preparedness and response.

-SPHL joined DCPH as it works closely with emergency response staff, Department Situation Room and CERT and many disease control, environmental and genetic aspects in DCPH.

EPHP in September 2007 and CHPI were formed in DCPH. BHI is now located in EPHP.
//2009//
An attachment is included in this section.

D. Other MCH Capacity

D.1. MATERNAL AND CHILD HEALTH FULL TIME EMPLOYEES (FTEs)
The number and location of DCH staff with related Title V Block Grant MCH responsibilities are listed in the attached document. This listing includes staff who provide planning, evaluation and data analysis capabilities.

The number of full-time employees is 121.71 as of May 31, 2005. In addition, there are 11.75 staff outside of DCH, located in Office on Women's Health, Office of Information Systems, State Center, Office of Epidemiology and the State Public Laboratory who provide support in the policies for women's health, development and maintenance of the databases, statistical reports, etc. and the performance of such tests as the newborn screening tests.

/2007/
The number of full-time employees is 131.08 as of May 31, 2006. In addition, there are 7.5 staff outside of DCPH, located in ITSD and the State Public Laboratory who provide support in the development and maintenance of the databases and the performance of such tests as the newborn screening tests.
//2007//

/2008/
The number of full-time employees is 123.01 as of May 31, 2007. In addition, there are 7.25 staff outside of DCPH, located in Information Technology Services Division and the State Public Laboratory, who provide support in the development and maintenance of the databases and the performance of such tests as the newborn screening tests.

//2008//

/2009/
The number of full-time employees is 130.23 as of June 2008, including the staff of the State Public Laboratory which is now located in DCPH. In addition, there are staff outside of DCPH, located in Information Technology Services Division, who provide support in the development and maintenance of the databases.
//2009//

/2010/
Number of full-time employees is 157.22 as of May 18, 2009.
//2010//

D.2. TITLE V SENIOR LEVEL MANAGEMENT POSITIONS
Also see attachment to the preceding section, III. State Overview, C. Organizational Structure.

Paula Nickelson, MEd., is the Director of DCH (the agency responsible for maternal, child and family health; nutritional health; chronic disease prevention and health promotion; and community health improvement programs and for the preparation of the MCH Block Grant annual plan and application). Ms. Nickelson serves as the Director of the Missouri Title V program and as the Director of the state's Children with Special Health Care Needs program. Ms. Nickelson has a distinguished career in the human services and management fields. Her experience in mid-Missouri includes roles as the Chief of the former Bureau of Family Health, Director of Clinical Services for the Rusk Rehabilitation Center and Director of Evaluation and Counseling for Advent Enterprises, Inc.

/2007/
Glenda R. Miller, RN, MPH, BC CHNCS, became Director of DCPH in August 2005; she had previously been Director of the former DHSS Division of Maternal, Child and Family Health. Ms. Miller's diverse background includes serving as: Director of Center for Local Public Health Services where she developed and monitored the Core Public Health Functions contract in 114 counties and evaluated effectiveness and efficiency of the public health system; Education/Training/Social Marketing Coordinator for Burrell Behavioral Health where she developed education and training for System of Care Federal Grant, designed a strategic plan for social marketing and coordinated training and social marketing for multiple agencies in six counties; Project Evaluator, Sinclair School of Nursing for University of Missouri-Columbia; Faculty Instructor for Southwest Missouri State University; Faculty/Instructor for Webster University; Director, Disease Management and Health Risk Assessment for Cox Health Plans; Medicaid Special Programs Manager for Cox Freeman Health Management Services; HIV/AIDS Care Service Coordination (Emergency Appointment) for Missouri Department of Health; Assistant District Administrator for Missouri Department of Health for 21 counties in Southwest Missouri; and Community Health Nurse Consultant for Missouri Department of Health.
//2007//

/2009/
Due to the additional responsibilities Glenda Miller has accepted including the addition of State Public Health Laboratory to DCPH, July 2007 Melinda Sanders assumed the responsibilities of Title V Director.
//2009//

Robin Rust, MPA, is the Deputy Division Director for DCH. In December 2002, Ms. Rust came to DHSS as Deputy Division Director for the former Division of Maternal, Child and Family Health. She has a distinguished public service career spanning over 22 years of service with DSS. Her experience as Assistant Deputy Director in the Division of Medical Services for policy on fee for service, strong management skills, extensive knowledge of provider and funding systems within the state and established relationships with many of DCH's external partners are invaluable.

/2007/
Susan Jenkins is the Deputy Director for DCPH in DHSS. Prior to her current Deputy Director position, Ms. Jenkins was Deputy Director of the Division of Environmental Health and Communicable Disease Prevention. She began her career in public health as the Director of the Office of Governmental Policy and Legislation for DHSS that serves as the departmental liaison office with the State Legislature, Congress and their staffs. Previously, Ms. Jenkins was with the Office of Administration for 22 years serving as a senior budget and policy analyst on elementary and secondary and higher education issues before becoming an Assistant Director for State Planning in the Division of Budget and Planning, Office of Administration, and served as co-chair of the Governor's Interagency Planning Council which helped initiate a state integrated strategic planning model throughout the state departments. Ms. Jenkins has a degree in Psychology from the University of Missouri-Columbia.
//2007//

/2008/
Harold Kirbey, BS in Sociology and graduate work at UM-C in Rural Sociology, was appointed Deputy Director of DCPH, November 1, 2006. Mr. Kirbey has served DHSS since 1987 in the positions of Health Program Representative, Management Analyst Specialist II, Bureau Chief and Chief of Office of Primary Care and Rural Health. His experience with DHSS, the legislature, LPHAs, primary care providers and other public health partners will serve DCPH well.
//2008//

/2010/
Tricia Schlechte, MPH, BSN joined DCPH as Deputy Director in October 2008. Ms. Schlechte has held a variety of positions during her 22 year career in Missouri's state health agency. As Deputy Director of Health and Public Health she provided oversight for LPHAs, environmental, communicable disease, nutrition, maternal child, and chronic disease programs. Served as Interim Director and Deputy Director for the Division of MCFH. Ms. Schlechte has promoted a systems approach to prevention and collaboration with partners to achieve public health goals.
//2010//

Deborah Goldammer, MA, MPA, is the Section Administrator for the Office of Fiscal Support (OFS) and provides fiscal and budgetary expertise for DCH. OFS processes invoices and contract payments for various sections and programs within the division. Ms. Goldammer has served both the legislative and executive branches of Missouri State Government in various capacities since 1976.

/2007/
Scott Clardy is the Administrator of the Section for Public Health Practice and Administrative Support (PHPAS) in DCPH. Mr. Clardy has over 18 years of experience in public health, including public health laboratory sciences and environmental public health. As the Administrator of PHPAS, Mr. Clardy oversees the Bureau of Fiscal Services that processes invoices and contract payments, BHI, CHI and BVR. Mr. Clardy holds a Bachelor of Science degree in Biochemistry from the University of Missouri-Columbia.
//2007//

/2008/
Jennifer Duncan, CPA, MPA, is the Chief of the Office of Financial and Budget Services (OFABS). OFABS provides fiscal and budgetary expertise for DCPH, analyzing and tracking budgets and ensuring smooth processing of invoices and contract payments for the sections and programs within the division. Mrs. Duncan, a Certified Public Accountant, holds a Masters of Public Administration degree from the University of Missouri-Columbia and a Bachelor of Science Degree with Special Honors in Accounting from Jacksonville State University. Mrs. Duncan is a member of the Association of Governmental Accountants and the Missouri Society of Certified

Public Accountants.
//2008//

/2010/
Kerri Tesreau, MBA, is the Director of Operations for DCPH. Mrs. Tesreau is primarily responsible for oversight of OFABS and state budget.

Jeff Zoellner, CPA, is Chief of the OFABS. Mr. Zoellner, holds a Bachelors Degree in Accounting from Southeast Missouri State University.
//2010//

Melinda Sanders, MS(N), RN, Section Administrator for MCFH in DCH, began her work at DHSS in 1998. Ms. Sanders has 26 years of nursing experience, including 12 years as a Family Nurse Practitioner. While at DHSS, Ms. Sanders worked as a Consultant Community Health Nurse for children with special health care needs and Chief of the former Bureau of Genetics and Disabilities Prevention before becoming Section Administrator. Ms. Sanders holds Bachelor of and Master of Science degrees in Nursing from the University of Missouri-Columbia.

/2007/
Ms. Sanders' title now is Section Administrator for Section for Healthy Families and Youth in DCPH.
//2007//

/2009/
Due to the additional responsibilities Glenda Miller has accepted including the addition of State Public Health Laboratory to DCPH, July 2007 Melinda Sanders, Administrator of Section for Healthy Families and Youth (HFY), assumed the responsibilities of Title V Director. The majority of the programs and activities receiving MCH Title V funding are located in HFY.
//2009//

/2010/
Cindy Wilkinson, MSW, is the Deputy Section Administrator for DHSS, DCPH, HFY. Ms. Wilkinson is an experienced administrator with expertise in various aspects of children's healthy development. Ms. Wilkinson holds a Bachelor of Science degree in Family and Environmental Resources from Northwest Missouri State University-Maryville and a Masters in Social Work from the UMC.
//2010//

Sherri Homan, RN, PhD, is the Section Administrator for OSEPHI in DCH. OSEPHI supports DCH in strategic planning; quality improvement initiatives; program evaluations; coordination of specific grants including MCH Title V Block Grant; public information dissemination; initiation and maintenance of surveillance systems, data management and reporting; and epidemiologic consultations and assistance. Dr. Homan began her work with DHSS in 1986 and has served as Deputy Division Director and as Assistant to the Director for Strategic Planning and Program Evaluation for the former Division of Chronic Disease Prevention and Health Promotion. Dr. Homan received an Associate Degree in Nursing from Missouri Western State College in St. Joseph, Missouri and completed her Bachelor's and Master's of Science in Nursing from the University of Missouri. Dr. Homan is a Family Nurse Practitioner and also completed her doctorate at the University of Missouri in the Department of Education.

/2007/
Dr. Homan now serves in the Office of Epidemiology in DCPH.

Dr. Bao-Ping Zhu, MD, MS (EIS '96) is the State Epidemiologist for Missouri and Chief of Office of Epidemiology (OOE) and oversees unit preparing MCH Title V Block Grant. Immediately prior to his current position, he was a Lead Maternal and Child Health (MCH) Epidemiologist with the

Division of Reproductive Health, Centers for Disease Control and Prevention (CDC) during 1998-2003, assigned to the Michigan Department of Community Health (MDCH) as the Chief MCH Epidemiologist. Dr. Zhu's main areas of expertise are in Perinatal and MCH Epidemiology. He has also researched and published in other fields, including the epidemiology of tobacco use and its health consequences, statistical methods in critical care medicine, nutritional epidemiology and epidemiologic theories. He was a co-author of the 1998 Surgeon General's Report on preventing tobacco use among youths. Dr. Zhu earned his MS degree in biostatistics from the University of Massachusetts School of Public Health in 1993 and his MD degree in Preventive Medicine (with concentration in Epidemiology) from the Chinese Academy of Medical Science/Peking Union Medical College in 1990. He was a CDC Epidemic Intelligence Service (EIS) Officer during 1996-1998 and had post-doctoral training in biostatistics and epidemiology at INSERM, France, during 1990-1991.
//2007//

/2009/
Dr. Sarah Patrick will be joining DHSS as the new State Epidemiologist and administrator of the Section of Epidemiology for Public Health Practices full time in June, 2008, as Dr. Zhu accepted the position of Deputy Resident Advisory for the Field Epidemiology Training Program at the China CDC. Dr. Patrick will be transitioning into the position February-May. Dr. George Turabelidze will continue to serve as interim State Epidemiologist and Dr. Nick Boshard will continue to provide oversight and management for daily operations until June. Dr. Patrick has extensive experience with CDC, Aberdeen Area Indian Health Service, and Michigan Department of Health; and served as a state epidemiologist for South Dakota Department of Health. She is on the faculty of the Department of Family Medicine with University of South Dakota School of Medicine where her teaching responsibilities include epidemiology and biostatistics. She is concluding her work as Director for National Center of Excellence in Women's Health Project for Region VIII.
//2009//

Nick Boshard, PhD, MPH, is in charge of the Quality Improvement, Planning and Evaluation (QIPE) in OSEPHI. QIPE supports the departmental and interagency planning and evaluation to better achieve healthy outcomes for women, infants, children, adolescents and children with special health care needs through grants development and management (including the Title V Block Grant and the State Systems Development Initiative [SSDI] Grant); program analysis and evaluation; statewide MCH need/capacity assessments; departmental strategic planning; and interagency planning and evaluation. Dr. Boshard has over 20 years of experience in the health field including executive positions with multi-hospital systems, teaching experience with the Graduate Program in Health Services Management (University of Missouri) and public health experience with the Centers for Disease Control (CDC).

/2007/
Dr. Boshard remains in charge of the grants development arm of OOE and supports the development and submission of major DHSS federal block grant applications including MCH Title V Block Grant Application, the Preventive Health and Health Services Block Grant, the State Systems Health Development Initiative Grant and other grant applications that support MCH populations in Missouri. Major program evaluations are conducted within DCPH and statewide assessments of the priority needs of MCH populations and the delivery capacity to meet those needs.
//2007//

MCH epidemiological capacity is enhanced through three full time Public Health Epidemiologists assigned to consult and evaluate MCFH related programs and activities: Pamela K. Xaverius, PhD; Venkata PS Garikapaty, PhD, MPH; and Linda Browning, PhD, MPH, RD.

/2007/
MCH epidemiological capacity is enhanced through a full time Public Health Epidemiologist

assigned to consult and evaluate maternal, child and family health related programs and activities: Venkata Garikapaty, PhD, MPH. Other Public Health Epidemiologists in the department devote a significant portion of their time researching MCH related issues: Sherri Homan, RN, PhD; and Bao-Ping Zhu, MS, MD, who is the State Epidemiologist for Missouri.
//2007//

/2009/
September 2007, Dr. BaoPing Zhu accepted the position of Deputy Resident Advisory for the Field Epidemiology Training Program at the China Centers for Disease Control and Prevention.
//2009//

/2010/
With the retirement of Dr. Boshard; Melinda Sanders, MS(N), RN, Section Administrator for HFY, Title V Director assumes responsibility for Title V Block Grant and statewide MCH need/capacity assessments.

May 2008, Mei Lin, MD, MSc, CDC MCH Epidemiology Assignee to DHSS from the CDC's MCH Epidemiology Program. Dr. Lin is Co-Leader of MCH Epidemiology Response Team, EPHP. Increasing MCH epidemiological capacity at state level, and providing epidemiological consultation and support to MCH related programs/activities.

July 2008, Mary Jo Mosley joined the MCH Epidemiology Response Team as PRAMS Data Manager/Analyst for the MCHBG Application. Supports MCH related research activities involving birth and death files.

February 2009, Supriya Nelluri joined the MCH Epidemiology Response Team as a Research Analyst III dedicated 100% towards MCHBG activities and MCH related data. //2010//

D. 3. PARENTS OF SPECIAL NEEDS CHILDREN

SHCN has a contract with a LPHA to administer the Family Partnership. Three Family Partners, employed by the LPHA, are paid with SHCN monies. FP members are chosen for their expertise as parents of special needs individuals. FP members participate in making SHCN policies and procedures and provide feedback on SHCN items.

/2009/
A statewide conference for parents was held in November 2006. Approximately 90 family members participated in this conference for the exchange of information and mutual education and support.
//2009//

/2010/
Approximately 103 family members participated in a statewide conference for parents for the exchange of information and mutual education and support in November 2007. //2010//
An attachment is included in this section.

E. State Agency Coordination

E.1. STATE ORGANIZATIONAL RELATIONSHIPS

Organization relationships among state agencies are illustrated in chart attached to Section III. C. Organizational Structure.

DHSS has several agreements or memoranda of understanding with other state agencies to

collaborate to serve Title V populations including DSS, DESE, DMH and Department of Natural Resources (DNR).

Special state commission (5 senators and 5 representatives from legislature and several department directors including DHSS Director) was established to assess future of Medicaid in Missouri and options to reform Medicaid.

/2009/
2007 Senate Bill 577, Missouri Health Improvement Act of 2007, includes renaming Missouri Medicaid to MO HealthNet.
//2009//

/2007/
January 2006 Governor Blunt created Missouri Healthcare Information Technology task force to recommend better ways state government and private organizations share healthcare information. DHSS Director Julie Eckstein chairs 14-member taskforce, http://www.dhss.mo.gov/HealthInfoTaskForce/index.html.
//2007//

Comprehensive Children's Mental Health Services Initiative, September 2004, requires state agencies to develop comprehensive children's mental health services system to focus greater public attention on state policy for greater mental health parity with physical medical services, managed care protections for plan members with mental disorders and access to needed medications.

Missouri Title V Agency was leader in establishing blueprint for development of DMH's comprehensive children's mental health system with emphasis on primary prevention.

/2007/
Paula Nickelson is DHSS representative on Comprehensive System Management Team (CSMT
//2007//

/2009/
Glenda R. Miller is representative; Melinda Sanders is alternate.
//2009//

/2010/
Cindy Wilkinson is representative.
//2010//

DCH Director, Deputy Director and MCFH Administrator collaborate with Healthy Start in Bootheel area, St. Louis and Kansas City and conduct quarterly conference calls. Healthy Start coalitions participated in 5-year Title V needs assessment.

/2007/
DCPH Director serves on Kansas City's Board of Directors and is represented on St. Louis Coalition's Board of Directors.
//2007//

DHSS actively participates in Missouri Medicaid Managed Care Quality Assessment and Improvement Advisory Committee to advise DMS on measurable population-based quality indicators, health policy that improves health status of Medicaid managed care clients and identification of "best practices" of MCH care.

DCH is sponsoring evaluation of Home Visiting Program with DSS and Children's Trust Fund with focus on effectiveness of different models.

/2007/
Evaluation completed and executive summary prepared.
//2007//

Collaboration continues with DHSS SHCN Service Coordination staff, other state agencies and local communities to enroll children in SCHIP and Medicaid.

/2007/
SHCN information system links with DMS to provide Medicaid status.
//2007//

ACM is provided by agreement SHCN has with DMS. SHCN authorizes medical necessity of in-home nursing services and provides Service Coordination for participants in HCY and Physical Disabilities Waiver (PDW).

SHCN has agreement with DDU to refer children who apply for SSI to SHCN area offices.

SHCN maintained contract with Department of Labor, Missouri Assistive Technology Project, to provide assistive technology for CSHCN families.

/2008/
Missouri Assistive Technology moved to DESE. SHCN continues contract.
//2008//

/2009/
SHCN continues Missouri Assistive Technology contract for variety of home access improvements, vehicle access and range of assistive technology devices for CSHCN.
//2009//

/2007/
Support Partner Program was eliminated June 2005. SHCN Adult Head Injury Program now facilitates MHIAC.
//2007//

Missouri Brain Injury Association manages family mentoring Support Partner Program.

DMH, DSS, DESE/Division of Vocational Rehabilitation and SHCN are streamlining intake process and service planning. Common HIPAA-compliant release of information form and data elements were agreed upon when electronic solution is available.

OHP began new cooperative effort with DNR to better monitor and intervene with public water systems fluoridated but optimal level of fluoridation not maintained.

/2008/
OHP began updating Missouri's public water systems fluoridation data received from DNR for CDC Water Fluoridation Reporting System (WFRS).
//2008//

/2009/
OHP provided DNR public water systems fluoridation data to CDC WFRS and continues to on annual basis.

OHP and CLPHS encourage collaboration with LPHAs on OHP activities to assist communities in taking ownership of their oral health and implement Preventive Services Program (PSP) for children.

//2009//

/2007/
OHP began working with DMH, State Schools for Severely Handicapped (SSSH), Sheltered Workshops, SHCN and Elks Mobile Dental Services to develop oral health networks for dental operatories in MRDD Regional Centers.
//2007//

/2008/
Pilot dental care access survey was conducted in a MRDD Regional Center September-October 2006.
//2008//

/2009/
OHP, DMH-MRDD and SHCN conducted 2007 state survey to examine oral health needs of SHCN people. See attachment.

OHP implemented Oral Health PSP in Elks Mobile Dental Van Program late 2007 and January 2008.

OHP works with: DESE's SSSHs to implement Oral Health PSP in 2008; MPCA to encourage more dental sites in FQHC and to present Infant Oral Care Training April 2008; Head Start State Collaboration Office; MO Head Start Association; Central MO Community Action Head Start.
//2009//

GNH [now GHC] coordinates governor-appointed Genetic Disease Advisory Committee that advises DHSS in quality assurance of delivery of services to residents with genetic conditions. It has 5 sub-committees (Newborn Blood Spot Screening, Newborn Hearing Screening, Cystic Fibrosis, Hemophilia and Sickle Cell Anemia) comprised of representatives from treatment centers, providers, physicians and consumers.

Missouri Fetal Alcohol Syndrome Action and Care Team (MOFASACT) was developed to have statewide concentrated focus on FAS for prevention and intervention activities and information shared among committee members including UMC, St. Louis Arc, DMH and DHSS. Federal Substance Abuse and Mental Health Services Administration (SAMHSA) offered consultant services for developing comprehensive plan for FAS prevention in Missouri.

/2007/
Also, McCambridge Substance Abuse Treatment Center, PAT, Office of State Courts Administrators, ParentLink, Saint Louis University and MOFASRAPP.
//2007//

/2008/
MOFASACT members include 2 university medical schools, 2 hospitals, 3 state agencies, a substance abuse treatment center, 2 interested citizens, family advocacy organization and 2 parenting organizations.
//2008//

/2009/
DHSS discontinued sponsorship of MOFASACT and co-chair responsibilities September 2007 to allow MOFASACT to participate in legislative advocacy and other issues.
//2009//

MCFH is teaming up with SIDS Resources, Inc., to send messages to reduce risk of SIDS (Back to Sleep campaign). February 2005 SIDS Resources completed project for GNH to educate hospital nursery room nurses on Back to Sleep and is doing short-term project with GNH for

Children's Hospitals and remaining general hospitals. December 2003 - April 2005 Safe Sleep Workgroup, chaired by DHSS and SIDS Resources and included child advocates from state and breastfeeding community (La Leche and IBLCE-The International Board of Lactation Consultant Examiners), met to develop Safe Sleep brochure.

/2007/
English and Spanish brochure distribution began to promote "safe sleep" for infants and decrease infant asphyxiation due to bed-sharing.

GHC will work with SIDS Resources to promote "safe sleep" conference with American Academy of Pediatrics (AAP) October 2005 recommendations.
//2007//

/2008/
Safe sleep brochure was updated with 2005 AAP "Safe sleep" recommendations.
//2008//

/2009/
May 2007 "Safe sleep" conference was held.
//2009//

/2010/
GHC and CTF develop statewide "safe cribs" program. Increased deaths in 2007 vital records statistics due to unsafe sleep practices. "Safe Sleep" brochure updated with 2007/2008 AAP recommendations.
//2010//

HSF [now HFY] facilitated development of FIMR committees to improve understanding of root causes of infant death and promote evidence-based interventions and solutions. FIMR continues in St. Louis Maternal Child Health Coalition in 3 zip codes targeted by St. Louis Healthy Start. FIMR program started January 2004 in Kansas City through Kansas City MCH Coalition.

/2007/
FIMR expanded to entire St. Louis City and County region.
//2007//

/2008/
FIMR continues in St. Louis City and County. Kansas City programs target same 5 zip codes as Kansas City Healthy Start.
//2008//

School Health in HSF works with DESE on school health initiatives, guidelines for school health programs, professional development for school nurses, etc.

/2007/
Collaboration includes DMH, DSS, Department of Agriculture, Missouri Association of School Nurses, Missouri Student Success Network, Missouri Coordinated School Health Coalition and Missouri School Boards' Association. Targeted audiences include school staff and parents.
//2007//

/2010/
School Health, DESE and MoCSHC developed and distributed to 523 school districts guidelines for SHAC formation. School Health collaborates with MoARE, MoSBA, NEA, DMH and DSS.
//2010//

Adolescent Health in HSF coordinates statewide Council for Adolescent and School Health (CASH).

Adolescent health consultation and education contract with Children's Mercy Hospital for Adolescent Medicine Consultation Services supports services of Adolescent Medicine Consultant, training, technical assistance and ADOLESCENT SHORTS sent to 6500 adolescent health and mental health professionals.

/2007/
CASH developed Missouri State Framework for Promoting Health of Adolescents to promote importance of addressing health needs of adolescents. 2006 DHSS completed public health assessment tool.

/2009/
Based on results of adolescent health system capacity assessment and quality improvement action plan, DHSS Adolescent Health Leadership Team was formed to strengthen capacity and coordination of DHSS programs and services to meet adolescent needs. Team merged with CASH to promote application of guiding principles and State Framework for Promoting Health of Adolescents.
//2009//

State coordinator represents DHSS on Governor's Substance Abuse Prevention Initiative Advisory Committee. Adolescent Health Program, Adolescent Medicine Consultants and DSS Chafee Foster Care Program collaborate on adolescent mental health issues training. STD/HIV/AIDS and Teen Pregnancy Prevention Team improves coordination of education and public health partners and develops youth-focused programming.
//2007//

/2009/
State adolescent health coordinator represents DHSS on Governor's Substance Abuse Prevention Advisory Committee, Missouri Youth/Adult Alliance, and Missouri Department of Transportation Youth Traffic Safety Committee.
//2009//

/2010/
MODOT Youth Traffic Safety Committee no longer exists. ADOLESCENT SHORTS sent to 6,000 adolescent health and mental health professionals.
//2010//

Injury and Violence Prevention Program (IVPP) in HSF coordinates Missouri Injury Control Advisory Committee, a forum for addressing injury issues and providing guidance on injury prevention initiatives and activities. Committee has state, local, public and private agencies and professionals. IVPP worked with Committee to generate baseline data for STATE INJURY PREVENTION REPORT CARD and design report, INJURIES IN MISSOURI: A CALL TO ACTION.

/2008/
IVPP works with Injury and Violence Prevention Advisory Committee to generate baseline data for report card and second edition of INJURIES IN MISSOURI: A CALL TO ACTION.
//2008//

/2010/
MIVPAC preparing the state's Injury and Violence Prevention Strategic Plan. IVPP working with MIVPAC to generate a report: INJURIES IN MISSOURI.
//2010//

IVPP serves as lead agency for Missouri SAFE KIDS Coalition; supports 8 SAFE KIDS coalitions. Coalitions seek to reduce accidents and injuries to children as result of motor vehicle accidents, falls, drownings, bicycle accidents, fires, recreational injuries and poisoning. Block grant funding was used to generate additional contract support for SAFE KIDS coalitions.

/2008/
IVPP supports 9 SAFE KIDS.
//2008//

/2009/
IVPP supports 8 Safe Kids.
//2009//

/2010/
IVPP supports 9 Safe Kids coalitions.
//2010//

/2007/
SAFE-CARE (Sexual Assault Forensic Examination-Child Abuse Resource and Education) Network, administered by DHSS and supported by a Medical Director and Advisory Council, provides medical evaluations to alleged victims of child maltreatment and training to physicians and nurse practitioners to conduct medical evaluations of alleged victims.

Other stakeholder groups: DESE, Center for Safe Schools at UMKC; Department of Labor and Industrial Relations; Department of Transportation, Division of Highway Safety and Missouri Coalition for Roadway Safety; Department of Public Safety, including Highway Patrol; Iowa; Kansas; Nebraska; SAFE KIDS Coalition and SAFE-CARE.

Folic Acid Program coordinates Missouri Folic Acid Advisory Committee activities (medical professionals and educators, March of Dimes, DESE, public health professionals, etc.) to enhance awareness of benefits of folic acid in preventing neural tube defects and increase consumption of folic acid by women of childbearing age.
//2007//

/2008/
MCH Coordinated Systems works with DESE, UM, DMH and Heartland Center to promote healthy and resilient communities to address mental wellness in MCH population, a Missouri MCH priorities.
//2008//

E.2. FQHCs/COMMUNITY HEALTH CENTERS

PRIMO (Primary Care Resource Initiative for Missouri) receives funding from Health Access Incentive Fund (HAIF) and assists in expanding dental services through FQHCs.

FQHCs work closely with DHSS OMH and Senior Services to address access and disparity health issues. DHSS programs refer many individuals to FQHCs for medical and dental care.

/2007/
OPCRH, OMH and CCDC partner with FQHCs to address access and disparity health issues.
//2007//

/2009/
OHP with PRIMO Partners encourages and supports dental students receiving funding from HAIF and being placed in FQHCs to improve oral health access. Out of 21 FQHCs, 19 deliver dental services in 40 sites; 2 more are building clinics within next year. Since July 2007 12 placements

(includes dentists and physicians with 1 additional dentist placement pending) have been made by PRIMO Partner MPCA. OHP works with UMKC School of Dentistry. PRIMO is currently adding funding for pediatric dentist residency ($10,000 for 1-year residency). PRIMO has changed academic eligibility for dental hygienists students to include associate degree rather than limiting eligibility to bachelor degree.
//2009//

/2010/
20 out of 21 FQHCs deliver dental services in 43 sites.
//2010//

E.3. LPHAs

DCPH entered into 109 LPHA contracts with over 250 short-term outcomes to build MCH community-based systems of care through support of public health intervention customized to each community.

/2007/
DCPH entered into 110 LPHAs contracts with 265 short-term outcomes.
//2007//

/2008/
In 2008 DCPH will enter into 112 LPHA contracts with 112 short-term outcomes while addressing Missouri's MCH priorities. New contracts allow selection of fewer outcomes in order for funds to be focused on selected outcomes.
//2008//

/2009/
In 2008 DCPH has entered into 112 LPHA contracts with 112 system-building outcomes to address Missouri's MCH priorities. Contracts include 3-year plan to address local MCH priority.
//2009//

/2010/
113 LPHA contracts.

AHP contracts with 4 LPHAs for TOP and contract with Mississippi County Health Department for evidence-based teen pregnancy prevention.
//2010//

/2008/
SHCN maintains contracts with LPHAs to provide service coordination for CSHCN and adult survivors of TBI.
//2008//

/2009/
FFY 2008 DCPH has LPHA contracts to provide CCHC services in 112 of 114 counties. Targeted health issues this contract year:
-obesity prevention
-asthma management in young children
//2009//

/2010/
FFY 2009 adds targeted health issue of inclusion of cyshcn in child care.
//2010//

E.4. TERTIARY CARE CENTERS

SHCN has approximately 600 provider contracts. Through provider agreements with tertiary care centers, pre-approved specialty and sub-specialty care is provided for CSHCN who otherwise would have no resources for health care services.

/2007/
SHCN continues approximately 600 provider contracts.
//2007//

/2008/
SHCN discontinued contracts with providers who had not submitted claims in past 3 years but maintains approximately 400 provider agreements and continues to attract and enroll new providers.

GHC's 4 university genetic tertiary center contracts to support statewide program and provide evaluation for genetic conditions, genetic screening, counseling, diagnostic evaluation of genetic conditions and outreach along with tracking and follow-up on all abnormal newborn screen results and consultation to health care providers on those disorders screened by Newborn Screening Program.
//2008//

E.5. UNIVERSITIES
DHSS contracts with Southwest Missouri State University (name becomes Missouri State University August 2005) to provide technical assistance, training and consultation services to birthing hospitals and centers operating universal newborn hearing screening programs.

/2007/
MSU contract is in effect for fiscal year 2007.
//2007//

/2010/
Audiologist consultant/deaf educator provide assistance and expert counseling in the Kansas City area. MOHear brings expertise to families during home visits to newly diagnosed babies with hearing problems.
//2010//

UM contract provided for statewide comprehensive Breastfeeding Educator Program presented to audience of physicians, educators, nurses, lactation consultants, etc., for training in basic lactation management skills needed in every WIC clinic and pediatrician office.

/2007/
Cystic Fibrosis Outreach Clinics contract with UM Health Care offers services in Cape Girardeau and Springfield areas.

/2010/
Contract with UMC to provide CF Outreach Clinic services in the Springfield area.
//2010//

ATODPA has educational outreach with UMC (to continue in 2007) in use of Missouri Model for Brief Smoking Cessation Training and CDC-funded grant MOFASRAPP (continuing through 2007), a collaboration of DHSS, UMC, DMH, St. Louis Arc and Missouri Institute of Mental Health.

/2009/
DHSS is not contracting with UMC through 12/08 for MO Model Training; MOFASRAPP grant expires 9/29/08.

//2009//

/2010/
School Health partners with UMC for regional workshops on evaluating web sites. MO Model Training offered as requested for providers through FY2009 using MCHBG.
//2010//

SHCN maintained UMKC, Institute for Human Development, contract to increase cultural competency of SHCN staff and providers.

SHCN contract with UMKC, Institute for Human Development, coordinates statewide multi-agency efforts to achieve ECCS grant outcomes.
//2007//

/2008/
UMKC fulfilled contract to increase cultural competency of SHCN staff.

Cystic Fibrosis Outreach Clinic contract offers services in Springfield areas.

ATODPA educational outreach with UMC contracted with an expert presenter in 2007 in use of Missouri Model for Brief Smoking Cessation Training and CDC-funded grant MOFASRAPP with 2 state agencies, university hospital, behavioral research arm of medical school and family advocacy organization.
//2008//

/2009/
UMC is no longer involved in this contracted activity; grant expires 9/29/08.
//2009//

/2010/
SHCN partners with UMKC, grantee for the MOFFHIEC and the MOPICS\cyshcn. SHCN represented on grant leadership council.

SHCN partners with UMC, grantee for the Autism Grant. SHCN represented on grant leadership council.
//2010//

Missouri Partnership for Enhanced Delivery of Services (MoPEDS), facilitated through Department of Health Psychology in UM School of Health Professions with assistance from SHCN, is developing coordinated system of care for CSHCN in mid-Missouri and encouraging local partnerships with family, health care providers, schools and state agencies.

/2008/
MoPEDs is facilitated through Thompson Center in UMC. SHCN works with UMC Training and Interdisciplinary Partnerships and Services (TIPS) for Kids, Leadership Education in Neurodevelopmental and Related Disabilities (LEND) training program in Missouri.

/2009/
CSHCN Service Coordinators attend LEND training. CSHCN staff provide training for LEND group.
//2009//

DHSS partnered with UM to enroll home visiting clients into Domestic Violence Enhanced Home Visitation-DOVE Project. DOVE is National Institutes of Health (NIH)-funded $3.5 million research project to test home visitation intervention to reduce domestic violence and improve lives of pregnant and postpartum women and their children.

//2008//

SHCN has contracts with LPHAs and UM-Mount Vernon to provide service coordination for TBI patients over 21.

WIC/Nutrition Services' contract with UM-School Nutrition Education Program provided sequential nutrition education curriculum for pre-K through 12th grade.

/2008/
WIC/Nutrition does not have this contract or project now.
//2008//

E.6. EPSDT

Monthly EPSDT (HCY) reports are available to LPHAs electronically on Mobius hosted on State Data Center mainframe. HSF is assisting LPHAs in using reports as related to their MCH contracts meeting constituents' needs.

/2008/
CLPHS assists LPHAs in using reports.
//2008//

Title V funds support LPHAs for purpose of establishing and maintaining an improved coordinated system capable of addressing targeted MCH issues for entire MCH population.

E.7. GRANTS AND OTHER COLLABORATIVE RELATIONSHIPS

Early Childhood Comprehensive Systems (ECCS) Grant was awarded to Missouri to assemble group of stakeholders to guide development of State Plan to create early childhood comprehensive system. DHSS is using interagency approach for leadership. DHSS, DESE, DMH, DSS and Head Start State Collaboration Office form steering committee. Larger coalition of stakeholders meets quarterly and includes family members and representatives from Children's Trust Fund; Citizens for Missouri's Children Crider Center; Departments of Corrections, Economic Development, Elementary and Secondary Education, Insurance, Mental Health and Social Services; Family Voices, FIMR Board, Head Start, Heart of America, Metro Council on Early Learning, Missouri Dental Association, MPCA, Parent Link, PAT, Partnership for Children, Project Life, Ozark Center, Southeast Missouri State University, Governor's Office, United Way and UM Hospital and Clinics.

ECCS Plan is structured along natural continuum from child and family through community and state and allows for participants/families to be involved in identification of their needs and decision-making process to meet needs. ECCS plan will be included in state strategic plan.

/2007/
Coalition includes Association for Education of Young Children, Missouri Dental Hygienists Association and Senate and House of Representatives.

SHCN contract with UMKC, Institute for Human Development, coordinates statewide multi-agency efforts to achieve ECCS grant outcomes.
//2007//

/2009/
ECCS grant was approved by Governor; newly created subcommittee of Children's Services Commission is entitled Early Childhood Coordinating Board. Board is to implement ECCS plan.
//2009//

/2010/
Collaborate with all stakeholders involved in creating an ECCS. Grant funding received for partnering with governor appointed CBEC and development of parent leadership resource/referral clearinghouse via a contract with UMKC.
//2010//

/2007/
SHCN obtained Missouri Foundation for Health (MFH) grant to promote MH concept and maintained contracts with Reynolds County Health and Wright County Health Centers to promote education of key stakeholders and assurance of long-range sustainability of MH system.
//2007//

/2008/
MFH grant cycle was completed and LPHA MH contracts were fulfilled. SHCN continues to distribute MH concept materials.
//2008//

Significant achievements occurred due to opportunities provided by Universal Newborn Hearing Screening Grant (continues through March 2006) to ensure diagnosis of congenital hearing loss by 3 months of age and entry into early intervention by 6 months of age. Regional representatives were hired to track infants who missed or failed initial hearing screening to assure linkage to early intervention services and MH. DHSS finalized agreement with DESE to share aggregate data (First Steps enrollment, intervention services, type of amplification, etc.) on children with confirmed hearing loss. Further collaboration with DESE is proceeding to share specific early intervention information to improve follow-up efforts.

/2007/
MNHSP was supported with general revenue funds, HRSA Universal Newborn Hearing Screening and Intervention, CDC Early Hearing Detection and Intervention and MCH Block Grant. Universal Newborn Hearing Screening Grant continues through March 2007; CDC grant until June 30, 2007.
//2007//

/2009/
HRSA Universal Newborn Hearing Screening Grant continues through March 2008. CDC grant continues until June 30, 2008. Applications for new grants will be completed for each.
//2009//

/2010/
HRSA UNHS continues until 3/31/2010. CDC EHDI grant continues until 6/30/2009. Will apply for new grants.
//2010//

DHSS was awarded FAS prevention CDC funding through September 28, 2008. Grant funds support development and implementation of MOFASRAPP. DMH, Missouri Institute of Mental Health, UMC, St. Louis Arc and MPCA are collaborating in project to reduce alcohol-exposed pregnancies, educate health care providers on FAS, establish FAS centers and enhance existing surveillance systems.

/2009/
Grant extension is being requested to continue surveillance and FAS center through 9/29/09.
//2009//

/2010/
Awarded two teen pregnancy, STD, and HIV prevention grants to develop evidence-based approaches and increase capacity.

//2010//

/2007/
CDC-funded MOFASRAPP (collaboration of DHSS, DMH, Missouri Institute of Mental Health, UMC and St. Louis Arc) continues through September 28, 2008, to develop and implement integrated systems framework for prevention and surveillance of alcohol-exposed pregnancies and FAS.
//2007//

/2009/
This grant portion expires 9-29-08.

GHC participates in ongoing activities of Heartland Regional Genetics and Newborn Screening Collaborative (HRGNSC) that included for 2007 distributed copies of prenatal DVD, "Newborn Screening: Protecting Your Baby's Health" which concerns newborn screening for expectant parents. DVD, in English and Spanish, was sent to prenatal clinics, midwifery clinics and birthing centers and assisted in development of family health history materials sent to state genealogy groups.

FY 09 HRGNSC will:
-focus on "Just in Time" primary care provider education project to give web-based information on heritable disorders;
-develop MH portal that involves information, tools and resources to aid primary care providers in caring for CSHCN and providing MH for their patients.

GHC distributed family health history materials through Area Agencies of Aging in conjunction with Grandparents day.

FY09 GHC and DMH will promote family health history.
//2009//

Some other federal funds DCH receives: State Systems Development Initiative (SSDI) Grant; Abstinence Only Education; TBI Grant; Rape Prevention and Sexual Assault Prevention Education Grant; Integrated Comprehensive Women's Health Services Grant; State Oral Health Collaborative Systems Grant; CDC Obesity Grant and HRSA State Planning Grant to study health insurance coverage (9/1/04-8/31/05).

Other funding and collaboration include: Food Stamp Nutrition Education Program; Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases; "Bridging the Gap between Abstinence-Only and Comprehensive Sex Education" conference sponsored by DHSS and DESE with public health and education agencies from Kansas and Iowa; Tobacco Cessation Among Women of Reproductive Age Team; partnership of DHSS and DMH in use of state funds and collaborations with community coalitions to generate local in-kind services and resources for first time focus on FAS conferences; Missouri Folic Acid Advisory Council coordination; Breastfeeding Peer Counseling Program.

/2008/
DHSS and DMH have discontinued use of state funds for FAS conference and community collaborations.
//2008//

/2009/
"Bridging the Gap between Abstinence-Only and Comprehensive Sex Education" conference changed to "Annual HIV/AIDS/STDs & Human Sexuality Education Conference".

OWH received grant from MFH to support Denim Day rape education and awareness initiative, a

collaboration between OWH and Injury and Violence Prevention.

Other federal funds: Preventive Health and Health Services Block Grant and African-American Infant Mortality Preventive Initiative grant funded by State Partnership Grant Program to Improve Minority Health in DHHS Office of Minority Health.
//2009//

/2010/
OHP grant from HRSA to Support Oral Health Workforce Activities.

CDC Obesity Grant no longer funded. Related Nutrition and Physical Activity Program also eliminated.
//2010//

E.8. FAMILY PARTNERSHIP (FP):

SHCN developed contract with LPHA contractor to provide FP services.

SHCN has LPHA focus on FP activities. Face-to-face meetings, monthly conference calls with FP family members and quarterly regional English/Spanish newsletters (uploaded to FP Web site) are means to share resource information and training on specific topics relevant to families with special needs individuals.

FP members participate in decision-making process for SHCN policies and procedures. SHCN fact sheets, brochures and forms are distributed for FP members' feedback.

FP provides outreach activities to encourage participation in FP meetings. SHCN explored and researched interest groups to assist in identification and recruitment of youth participation.

/2007/
FP continues LPHA contract for statewide activities with an increase in participation of face-to-face meetings. Core group of 15 Family Partners review SHCN materials to assure appropriate resources are utilized with families. Family Partners continue to build contacts and professionals network.
//2007//

/2008/
FP continues through LPHA contract. Face-to-face meetings and newsletters continue. SHCN maintains FP Web Site. Family Partners continue to review SHCN materials and conduct outreach activities.
//2008//

/2009/
Approximately 90 family members participated in November 2006 state conference to exchange information and mutual education and support.
//2009//

/2010/
About 103 family members participated in November 2007 conference.

About 100 participated in Newborn Screening conference held in April 2009.
//2010//

F. Health Systems Capacity Indicators

Introduction
While the majority of the activities listed below are funded in some portion (staffing, supplies, etc.), there may be some which do not receiving funding from the MCH Title V Block Grant but still impact the health systems capacity indicator.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	39.3	34.6	36.4	31.7	31.7
Numerator	1460	1326	1406	1245	1245
Denominator	371829	383096	386752	393177	393177
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Source: Numerator is from DHSS patient abstract system, inpatient hospitalization data. Provisional 2007 used as proxy for 2008. Final hospital discharge information & 2008 population will be available November, 2009.
Population estimate for 2007 is used as proxy for 2008 denominator, obtained from Missouri Information for Community Assessment (MICA)-Population.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Inpatient Hospitalization, and the Bureau of Health Informatics, MO DHSS. 2007 data will be available in December 2008, and 2006 data are used as proxy for 2007.

Notes - 2006
The data is from the Patient Abstract System. There is a one year lag time in receiving data from the reporting hospitals. Current 2006 data won't be available until Fall, 2007. 2005 estimate used for 2006 denominator until more current numbers available.

The numerators and denominators have been revised to include only MO residents with an ICD-9 Code of 493.0 - 493.9.

Narrative:
--Missouri Asthma Prevention and Control Program (MAPCP) Web site (http://www.dhss.mo.gov/asthma/RelatedLinks.html) provides information and links for schools and child care centers regarding controlling asthma symptoms, preventing most acute asthma attacks and maintaining desired activity levels. Links are provided to the 2005 Missouri state asthma plan and the 2005 Missouri School Asthma Manual. Partners include Asthma & Allergy Foundation of America-Greater Kansas City Chapter, Missouri Pharmacy Association, DESE, Missouri Medicaid, Glaxo-Smith Kline, Sinclair School of Nursing, Missouri DNR-Air Pollution Control Program, DSS-FSD, St. Louis City Department of Health, Kansas City Health Department, Missouri School Nurses Association, Missouri Hospital Association, American Lung Association, Missouri School Boards' Association, Kansas City Missouri School District, St. Louis University-School of Public Health, Missouri Primary Care Association, Greater Kansas City Black

Nurses Association, Allergy and Asthma Consultants, St. Louis Regional Asthma Consortium and University of Missouri Outreach and Extension.

--"Improving Missouri School Asthma Services" is a collaborative effort of DHSS, Missouri School Boards' Association, Missouri Association of School Nurses and University of Missouri-Columbia to equip local school nurses to support children who have asthma, increase awareness and support among school staff and board members and partner with parents to meet needs of children and reduce disabling effects of poorly controlled asthma.

--School Health Capacity Building-Title V and state funding supports the School Health Services program (a collaborative effort of DHSS, DSS and DESE) in funding special contracts with public schools, public school districts and LPHAs to establish or expand population-based health services for school-age children in defined geographic areas. It focuses on increasing access to primary and preventive health care for school-age children; identifying school-age CSHCN and referring them to a system of care; and providing professional education to school health professionals who work with school-age children who may be overweight, at risk for being overweight, or have diabetes, asthma, or attention deficit hyperactivity disorder (ADHD).

--CSHCN Service Coordination-The Hope Service provides assistance for children birth to age 21 who meet financial and medical eligibility guidelines. This service focuses on early identification of children with special needs; funding for preventive, diagnostic and treatment services; and provision of service coordination activities for families. Service coordination is provided through 13 regional contracts and by SHCN staff located in area offices throughout the state.

--Coordination and Systems Development-Title V funds are used to support staff in DCPH to carry out activities related to coordination of state and local agencies in data collection, analysis and data processing.

--Epidemiological Services-Title V funds will be used to fund epidemiological consultation services to provide technical assistance to identify factors impacting MCH health status.

/2009/
Child Care Health Consultation (CCHC) -- This cooperative program between DHSS and LPHAs provides on-site consultation, education and health promotion services to child care facilities. Appropriate asthma management in young children has been a two-year focus of this program with the intent of decreasing emergency room visits of young children for asthma related complaints. In FFY 2007, 313 hours of group education and 14 hours of on-site consultation were provided to a total of 1,864 child care providers and 53 parents of children in child care.
//2009//

/2010/
CCHC Program remains involved in the promotion of the management of asthma in young children. In FFY 2008, 257 additional hours of group education regarding asthma management and 36.25 hours of on-site consultation for the purpose of creating individual asthma action plans were provided to a total of 1,311 child care providers and 50 parents of children in child care.
//2010//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	89.2	91.9	92.8	90.8	90.7
Numerator	31672	34465	40497	40857	41175

Denominator	35517	37488	43619	44982	45389
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: Division of Medical Services, Mo HealthNet, Dept of Social Services. Numerator is number of Mo HealthNet (Medicaid) enrollees (including SCHIP) age less than one year in FFY 2008 who received at least 1 periodic screen. Denominator is number of Mo HealthNet enrollees (including SCHIP) whose age is less than one year in FFY 2008.

Notes - 2007
Source: MO HealthNet Division, Missouri Department of Social Services.

Numerator is the number of Medicaid enrollees (including SCHIP) whose age is less than one year in FFY 2007 who received at least one initial or periodic screen. Denominator is the number of Medicaid enrollees (including SCHIP) whose age is less than one year in FFY 2007.

Notes - 2006
Both numerator and denominator obtained from Division of Medical Services. Denominator = total eligibles < 1 year of age who should receive at least one initial or periodic screening in 2006 = 43619. Numerator = total eligibles < 1 year of age who received at least one initial or periodic screening in 2006 = 40,497. Numerator and denominator were then multiplied by the proportion of individuals 0-19 years of age enrolled in Medicaid (0.876, obtained from Form 21, HSI #09A) vs. those enrolled in SCHIP + Medicaid.

Narrative:
--CSHCN Service Coordination-The Hope Service provides assistance for children birth to age 21 who meet financial and medical eligibility guidelines focusing on early identification of children with special needs; funding for preventive, diagnostic and treatment services; and providing service coordination activities for families through 13 regional contracts and by SHCN staff located in area offices throughout the state.

--Home Visiting-Funds are allocated to Missouri Community-Based Home Visiting Program (MCBHV) and Building Blocks of Missouri to provide home visiting services for high-risk pregnant women and infants at risk of infant mortality or morbidity and abuse or neglect. Home visiting services include referral and case management services. In 2005 the program was expanded to the St. Louis City/County region through a contract with the St. Louis County Health Department.

--Child Care Initiatives-Funds are used to enhance child care resource and referral (CCR&R) services for families and CSHCN.

--Coordination and Systems Development-Title V funds are used to support staff in DCPH to carry out activities related to coordination of state and local agencies in data collection, analysis and data processing.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	89.2	91.9	92.8	90.8	90.8
Numerator	5336	4879	582	433	442
Denominator	5984	5307	627	477	487
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: Mo HealthNet Division, Dept of Social Services. Revised in 2006 to reflect more accurate percentage. Denominator is final 2008 number of SCHIP enrollees <1 year of age in FFY 2008. Mo HealthNet tracks only total (Mo HealthNet clients plus SCHIP)EPSDT numbers but does not track SCHIP EPSDT numbers for this age group. Numerator estimate is multiplication of the number of Mo HealthNet (including SCHIP) enrollees <1 year who received at least 1 screen (41,175) from HSI #2 by the percent of SCHIP enrollees under 1 year (487/45,389=0.0107. FFY 2008).

Notes - 2007
Source: MO HealthNet Division, Missouri Department of Social Services.

The method to determine denominator and numerator for this measure was revised to reflect more accurate information on SCHIP. The denominator is the number of SCHIP enrollees less than one year of age in FFY 2007. MO HealthNet only tracks total HealthNet (Medicaid including SCHIP) EPSDT numbers for children under one year of age, but does not track SCHIP EPSDT numbers for this age group. Therefore, the numerator is estimated by multiplying the number of Medicaid (including SCHIP) enrollees under one year of age who received at least one initial periodic screen (40,857 in FFY 2007, HSCI #2) by the proportion of SCHIP enrollees under one year of age among the total number of Medicaid (including SCHIP) enrollees under one year of age (477 / 44,982 = 0.0106, FFY 2007).

2006 denominator and numerator were also changed based on the revised method.

Notes - 2006
Both numerator and denominator obtained from Division of Medical Services. Numerator and denominator were obtained by multiplying the proportion of individuals 0-19 years of age enrolled in SCHIP (0.126, obtained from Form 21, HSI #09A) vs. those enrolled in SCHIP + Medicaid.

Narrative:
--Collaboration continues among DHSS SHCN Service Coordination staff, other state agencies and local communities to identify and help enroll children in Missouri's SCHIP and Medicaid.

--CSHCN Service Coordination-The Hope Service provides assistance for children birth to age 21 who meet financial and medical eligibility guidelines focusing on early identification of children with special needs; funding for preventive, diagnostic and treatment services; and providing service coordination activities for families through regional contracts and by SHCN staff located in area offices throughout the state.

--MCH Coordinated Systems Contracts with LPHAs establish and maintain an integrated multi-tiered service coordination system. Funds are disbursed using an outcome-based contract to LPHAs with a contractual obligation to use evidence-based interventions to address identified health risk indicators such as percent of children without health insurance.

/2009/
In 2007, MCH Coordinated Systems contracted with LPHAs to establish and maintain an improved coordinated system within their communities to address periodic screening for children under one year of age. In 2008, contracts with LPHAs have changed the focus to injury prevention, obesity and tobacco prevention. Funds are disbursed using an outcome-based contract to LPHAs with a contractual obligation to use evidence-based interventions to address identified health risk indicators. LPHA contractors may also continue to address periodic screenings.
//2009//

/2010/
In 2009, funds continue to be disbursed using an outcome-based contract to LPHAs with a contractual obligation to use evidence-based interventions to address identified health risk indicators. LPHA contractors may also continue to address periodic screenings.
//2010//

--Home Visiting-Funds are allocated to MCBHV and Building Blocks of Missouri to provide home visiting services for high-risk pregnant women and infants at risk of infant mortality or morbidity and abuse or neglect. Home visiting services include referral and case management services. In 2005 the program was expanded to the St. Louis City/County region.

--Child Care Initiatives-Funds are used to enhance child care resource and referral (CCR&R) services for families and CSHCN.

/2009/
CCHC program provides consultation and education to child care providers related to the care of children with special heath care needs such as asthma, diabetes, seizures, autism and ADHD.
//2009//

/2010/
CCHC program continues to provide consultation and education to child care providers and young parents of children in child care related to the care of children with special heath care needs. A new lesson plan helping child care providers examine their capacity to accept cyshcn is being offered across the state in FFY 2009.
//2010//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	78.5	79.2	77.2	75.2	74.3
Numerator	61010	62177	62764	61545	60103
Denominator	77709	78547	81353	81883	80868
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source: Birth Data, DHSS Vital Statistics. 2008 provisional data as of April 2009. Final birth information will be available October 2009.

MO experienced a slight but noticeable decline in this measure in the past three years 2006-08. The decline was slightly larger for Medicaid population than for non-Medicaid population. This decline is attributable to a lack of OB health care providers, especially in the southeast segment of the state and those willing to serve the Medicaid population. In addition, it appears that OB providers utilizing a software program for prenatal visits are transferring records to the anticipated birth hospitals earlier in the pregnancy (i.e.: 36 weeks) and fail to send subsequent visits giving the appearance an inadequate number of prenatal visits occurred. Adequate prenatal care (PNC) followed the similar pattern observed for early PNC. MO will continue to investigate the effect of this practice.

As explained for the National Performance Measure #18 - early PNC, more recent changes to welfare and Medicaid policy might limit further improvements in adequate PNC. Change in reporting system might also be a factor.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Births,
and the Bureau of Health Informatics, MO DHSS. 2007provisional data as of April 28, 2008. 2007 final birth data will be available in October 2008.

Narrative:
--Baby Your Baby Web site (www.dhss.mo.gov/babyyourbaby) has information for pregnant women, their families and communities on healthy pregnancies and healthy babies. Topics and links include prenatal care and nutrition, MC+ (Medicaid), WIC, and TEL-LINK that is a toll free information and referral line.

--Campaign ads were developed with the Missouri Broadcaster's Association for messages to promote healthy pregnancy through early and adequate prenatal care. Ads promote the importance of the family history to identify health problems that run in the family which can help doctors better determine the risk of disease among their patients and help motivate them into action to stay healthy.

--The WIC Program provides various assistance including medical referrals to health care providers to address the WIC participants needs.

--MCH Coordinated Systems Contracts with LPHAs --Title V funds support LPHAs for the purpose of establishing and maintaining a system capable of addressing adequate prenatal care. Two performance measures were addressed in jurisdictions where the data was most disparate: Increase the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester (11 LPHAs); and Decrease the percent of pregnant women receiving inadequate prenatal care (13 LPHAs).

/2008/
Contracts with LPHAs have been renewed with the focus on the objectives on injury prevention, obesity and tobacco. Local contractors will continue to address the issue of adequate prenatal care with local funds.
//2008//

--Healthy Babies-This initiative provides educational materials through the Web site and printed materials in English and Spanish that promote healthy pregnancies and healthy birth outcomes and encourages early entry into prenatal care. The Web site (www.dhss.mo.gov/babyyourbaby)

will be active through January 2008.

/2009/
This contract has been renewed through January 2013.
//2009//

--Home Visiting-Funds are allocated to MCBHV and Building Blocks of Missouri to provide home visiting services for high-risk pregnant women and infants at risk of infant mortality or morbidity and abuse or neglect. In 2005 the program was expanded to the St. Louis City/County region through a contract with the St. Louis County Health Department.

--Genetic Services-Title V partially funds the program's contributions in the reduction of morbidity and mortality associated with genetic disorder. The genetic disease program maintains a referral network that connects Missourians in need of diagnostic treatment, counseling and specialized health services with appropriate health care providers.

/2009/
General revenue funds support the metabolic formula program to provide for those of any age, including pregnant women, who require formula and who qualify under the financial guidelines.
//2009//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	81.8	80.0	79.7	79.2	79.1
Numerator	324000	356000	358000	361000	412000
Denominator	396000	445000	449000	456000	521000
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Accurate number of potentially Mo HealthNet (Medicaid) eligible children is not available. Estimate of denominator and numerator are from US Census, Current Population Survey, Annual Social & Economic Supplement, 2008.
Source: http://www.census.gov/cgi-bin/broker. Numerator is children age 17 years and under below 300% of FPL with Mo HealthNet coverage. Denominator is number of children age 0-17, below 300% FPL with Mo HealthNet coverage plus children age 0-17 below 300% FPL, and not covered by Mo HealthNet (uninsured).

Notes - 2007
Accurate number of potentially Medicaid-eligible children is not available. Estimates of denominator and numerator are obtained from Current Population Survey Table Creator on the Census Bureau website:

http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Numerator = Number of kids of ages 0-17, below 300% FPL, and on Medicaid.
Denominator = Number of kids of ages 0-17, below 300% FPL, and on Medicaid + Number of kids of ages 0-17, below 300% FPL, and not on Medicaid (uninsured).

Notes - 2006
Accurate Medicaid eligibility information currently not available. Estimates of denominator and numerator are obtained from Current Population Survey Table Creator on the Census Bureau website:

http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Numerator = Number of kids of ages 0-17, below 300% FPL, and on Medicaid.
Denominator = Number of kids of ages 0-17, below 300% FPL, and on Medicaid + Number of kids of ages 0-17, below 300% FPL, and not on Medicaid (uninsured).

Narrative:
--CSHCN Service Coordination-The Hope Service provides assistance for children birth to age 21 who meet financial and medical eligibility guidelines focusing on early identification of children with special needs; funding for preventive, diagnostic and treatment services; and providing service coordination activities for families through 13 regional contracts and by SHCN staff located in area offices throughout the state.
/2010/
--Collaboration continues among DHSS SHCN Service Coordination staff, other state agencies and local communities to identify and help enroll children in Missouri's MHN. //2010//
--Home Visiting-Funds are allocated to MCBHV and Building Blocks of Missouri to provide home visiting services for high-risk pregnant women and infants at risk of infant mortality or morbidity and abuse or neglect. Home visiting services include referral and case management services. In 2005 the program was expanded to the St. Louis City/County region through a contract with the St. Louis County Health Department.

--Outreach and Education-TEL-LINK is partially funded by Title V to support the maintenance and promotion of the state's toll-free telephone referral service. This service offers callers information and direct referrals to health-related services available in local communities and statewide. In January 2005, the TEL-LINK Web site was developed. During this year, a total of 9,984 hits were made to the Web site. Collaboration with other state programs and agencies was developed to promote the program and other health care benefits. Outreach was provided through direct mailings and exhibits at various conferences and health fairs to promote the program and distribute health educational materials to Missourians.

/2008/
In year 2006, promotion of TEL-LINK was provided through direct mailings, distribution of health education materials and exhibits at various conferences and health fairs. The toll free number was utilized in collaboration with other state health programs such as Cancer and Chronic Disease Control. The TEL-LINK Web site continues to serve as another avenue for promoting the program to Missourians. A link to the TEL-LINK Web site was added from the department's home page.
//2008//

/2009/
In year 2007, promotion of TEL-LINK in collaboration with programs in DCPH provided additional marketing opportunities for individuals to call the toll free number and receive referrals to social services agencies, which provide Medicaid services to children.

//2009//

/2010/
In year 2008, promotion of TEL-LINK was provided through advertisements in various parenting, health and community publications, exhibits at various health conferences and health fairs to promote the program, and distribution of health educational materials to Missourians. The toll free number was utilized in collaboration with other state health programs such as WIC and Nutrition Services and provided additional opportunities for individuals to receive referrals to social services agencies, which provide MHN services to children. The TEL-LINK Web page continues with a link from the DHSS homepage. A total of 8,032 hits were made to the TEL-LINK Web site in 2008.
//2010//

--Child Care Initiatives-Title V Block Grant funds are used to enhance Child Care Resource and Referral (CCR&R) services for families and CSHCN. Through this project the CCR&R has qualified inclusion staff in every CCR&R agency to provide statewide-enhanced services listed below:
-Referrals will remain an integral part of services delivered. All eight local agencies will maintain toll-free phone numbers. Families may call and seek referrals to child care programs. Referral Specialists will collect data such as: immunization status of children, health issues including diseases and birth defects, developmental issues and insurance status of children.
-Call-enhanced services with development of a plan of action, in collaboration with the family, to support child care services to a child with special needs.
-Referrals of all families of children with special needs to Missouri's Early Intervention Programs (First Steps), local Public School District or other appropriate programs or services.

/2009/
The CCHC program provides information to child care providers and parents of children in child care regarding a source of health care coverage, primary care services and specialty care services as requested.
//2009//

/2010/
The CCHC program continues to provide information and education to child care providers and parents of children in child care regarding a source of health care coverage, primary care services and specialty care services as requested.

The School Health Program provides an annual update for school nurses on MHN and how to assist families to enroll.
//2010//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	34.2	33.7	35.0	38.3	37.5
Numerator	42268	43175	45850	47818	47298
Denominator	123636	128262	131054	124885	126014
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: Mo HealthNet Division, Dept of Social Services. Numerator is the number of EPSDT eligible children age 6-9 years receiving any dental services in FFY 2008. Denominator is the number of children age 6-9 years eligible for EPSDT in FFY 2008.

MO experienced a decline in this measure as compared to 2007, yet the rate remains higher than 2004 through 2006. It is anticipated this rate will continue to rise in the future based on the fact Medicaid requires all of their Managed Care Plans to conduct a performance improvement project on improving this rate for all children enrolled.

Notes - 2007
Source: MO HealthNet Division, Missouri Department of Social Services.
Numerator is the number of EPSDT eligible children aged 6-9 years receiving any dental services in FFY 2007. Denominator is the number of children aged 6-9 years eligible for EPSDT in FFY 2007.

Notes - 2006
Both numerator and denominator obtained from Department of Social Services, Division of Medical Services. Denominator = eligibles 6-9 years of age who received corrective treatment in 2006 + eligibles 6-9 years of age who received any dental services in 2006 + eligibles 6-9 years of age who received preventive dental services in 2006 + eligibles 6-9 years of age who received dental treatment services in 2006 = 131,054. Numerator = eligibles 6-9 years of age who received any dental services in 2006 (45,850).

Narrative:
--Oral Health Program (OHP)-OHP provides preventive and restorative dental services through Elks Mobile Dental Program, Oral Health Preventive Services Program, DDS Program and Fluoride Mouthrinse Program and preventive dental services initiatives. Recipients of Elks Mobile Dental Program services include CSHCN and other vulnerable children. Children in Head Starts, Early Head Start and elementary school are screened, educated, referred and provided fluoride varnish through Oral Health Preventive Services Program. With Missouri Dental Association, OHP finances DDS which utilizes network of volunteer dentists to provide comprehensive dental care to low-income maternal and child health populations in most need of care, at no charge to patient.

/2008/
Children in Early Childcare Centers are screened, educated, referred and provided fluoride varnish through Oral Health Preventive Services Program. Interactive Missouri maps on DHSS Web site identify fluoridated public water systems and oral health programs/services. Kindergarten-12th Grade Oral Health Education Curriculum is available on DHSS Web site. Other oral health education brochures/pamphlets have been updated.
//2008//

/2009/
So far in 2007-2008 school year, 15,676 children have participated in the Oral Health PSP ranging from ages of less than 1 year old to 18 years of age.

The K-12 Oral Health Education Curriculum is nationally and internationally known and has had exceptional positive reviews.

The Web site www.mohealthysmiles.com was established in 2007 to provide information to the public on the Oral Health Preventive Services Program. Radio media spots help promote the

program as well as promote good oral health care.

The Oral Health PSP is enhancing its training process by developing online training modules. This enhancement will make it possible for many additional dental professionals to be trained and be able to volunteer their services to the program.

In 2007-2008, Oral Health Intervention Topic Modules were developed and added to MICA on DHSS Web site to assist communities and public health professionals in assessing their public health needs and developing initiatives to address oral health issues in their communities.
//2009//

/2010/
To date, 32,131 children have participated in the Oral Health PSP.

K-12 curriculum available in Spanish.

Online training modules have been developed and are utilized to provide PSP training.

School Health Program performance measure(s) related to oral health education for school age children/administration of topical fluoride and assists schools to maintains list(s) MHN providers for oral health services.

TEL-LINK Web site serves as an opportunity for individuals to identify dental service resources.
//2010//

--CSHCN Service Coordination-The Hope Service provides assistance for children birth to age 21 who meet financial and medical eligibility guidelines focusing on early identification of children with special needs; funding for preventive, diagnostic and treatment services; and providing service coordination activities for families through 13 regional contracts and by SHCN staff located in area offices throughout the state.

--Outreach and Education-TEL-LINK is partially funded by Title V to support the maintenance and promotion of the state's toll-free telephone referral service. This service offers callers information and direct referrals to health-related services available in local communities and statewide.

/2008/
In year 2006, promotion of TEL-LINK was provided through direct mailings, distribution of health education materials and exhibits at various conferences and health fairs. The toll free number was utilized in collaboration with other state health programs such as Cancer and Chronic Disease Control. The TEL-LINK Web page continues to serve as another avenue for promoting the program to Missourians. A link to the TEL-LINK Web site was added from the department's home page.
//2008//

/2009/
In year 2007, promotion of TEL-LINK in collaboration with programs in DCPH provided additional marketing opportunities for individuals to call the toll free number and receive referrals to resources providing dental services.
//2009//

--Child Care Initiatives-Title V Block Grant funds are used to enhance CCR&R services for families and CSHCN. CCR&R has qualified inclusion staff in every R&R agency to provide statewide-enhanced services:
-Referrals remain an integral part of services delivered. All 8 local agencies maintain toll-free phone numbers. Families may call and seek referrals to child care programs. Referral Specialists

will collect: immunization status of children, health issues including diseases and birth defects, developmental issues and insurance status of children.
-Call-enhanced services with development of plan of action with the family to support child care services to a child with special needs.
-Referrals of all families of children with special needs to Missouri's Early Intervention Programs (First Steps), local Public School District or other appropriate programs or services.

/2008/
Local CCR&R's provide oral health training to child care providers as part of Basic Child Care Orientation Training supported by DHSS and DSS.
//2008//

/2009/
The CCHC program provides information to child care providers and parents of children in child care regarding a source of health care coverage, primary care services and specialty care services
as requested.
//2009//

/2010/
CCHCs educating child care providers on oral health.
//2010//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	75.5	73.6	84.4	81.4	81.6
Numerator	13653	14308	14434	14421	14668
Denominator	18075	19451	17109	17727	17979
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Denominator is number of Missouri SSI recipients under age 16 years as of December 2008.
Source: Social Security Administration Supplemental Security Record.
http://www.hrtw.org/youth/data/html.#ssi
Numerator is the number of Missouri Mo HealthNet enrollees referred for SSI supported rehab services as of December 2008 under age 16.

Notes - 2007
Denominator is the number of SSI recipients under 16 years old in Missouri, December, 2007.
Source: Social Security Administration, Supplemental Security Record, available at
http://www.hrtw.org/youth/data.html#ssi

Numerator is the number of Missouri Medicaid recipients <16 years of age who are referred for SSI supported rehabilitative services as of December 31, 2007. Source: Missouri Department of

Social Services, Research and Evaluation Unit.

Annual indicator for 2006 was revised based on the denominator the number of SSI recipients under 16 years old in Missouri, December, 2006. Source: Social Security Administration, Supplemental Security Record. The indicator 2005 and earlier was based on the denominator for ages under 18 years. Therefore the percents for 2007 and 2006 are not comparable with those for 2005 and earlier.

Notes - 2006
In order to better reflect the number of kids with special health care needs who are receiving rehabilitative services, for 2004 the definition of "State's CSHCN program" was broadened to include numbers of children that are served by Medicaid for SSI supported rehabilitative services. The denominator is the total number of children < 18 years of age in Missouri receiving SSI payments in December, 2005 (provisional 2005 number used). Denominator provided by SSI State Statistics Report for Missouri. The numerator is the total number of children < 16 years of age in Missouri in Medicaid that are referred for SSI supported rehabilitative services in December, 2006. Numerator provided by Missouri Department of Social Services, Research and Evaluation Unit.

Narrative:
--CSHCN Service Coordination-The Hope Service provides assistance for children birth to age 21 who meet financial and medical eligibility guidelines. This service focuses on early identification of children with special needs; funding for preventive, diagnostic and treatment services; and provision of service coordination activities for families. Service coordination is provided through 13 regional contracts and by SHCN staff located in area offices throughout the state.

During FY2005, the Injury and Violence Prevention Program partnered with the Special Health Care Needs Unit (SHCN) to assess the safety needs of CSHCN and acquire equipment to increase the safety of those children. SCs in the SHCN Unit documented unmet needs and coordinated the purchase of safety equipment for CSHCN and their families. Items purchased included 166 baby gates, 202 child safety kits, 488 first aid kits, 119 helmets and pads, 52 infant head supports, 321 smoke/carbon monoxide detectors and 207 thermometers.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	payment source from birth certificate	9.1	7.2	8.1

Narrative:
--FIMR Development-Funds will continue to be used in supporting and expanding existing FIMR boards/projects in local communities to examine the causes of fetal and infant deaths not examined by the Child Fatality Review Board and to recommend policy, program or systems changes which may reduce the rate of fetal infant mortality.

--Epidemiological Services-Title V funds will be used to fund epidemiological consultation services regarding needs assessment and evaluation of maternal and child health (MCH)

programs and to provide technical assistance to identify factors that affect infant mortality, injury prevention and other issues impacting MCH health status.

/2010/
The home visiting and alternatives to abortion programs continue to educate pregnant women on the importance of early entry into and regular prenatal care. Nurses in the Building Blocks program educate the mothers on the signs and symptoms of preterm labor and contact the woman's healthcare provider should symptoms develop. A physical assessment of the mom and fetus on every visit is completed by the nurse. The Building Blocks program rate of low birth weight infants is lower than the state rate for a comparable population.
//2010//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2008	matching data files	8.4	5.3	7.1

Narrative:
--FIMR Development-Funds will continue to be used in supporting and expanding existing FIMR boards/projects in local communities to examine the causes of fetal and infant deaths not examined by the Child Fatality Review Board and to recommend policy, program or systems changes which may reduce the rate of fetal infant mortality.

--Epidemiological Services-Title V funds will be used to fund epidemiological consultation services regarding needs assessment and evaluation of maternal and child health (MCH) programs and to provide technical assistance to identify factors that affect infant mortality, injury prevention and other issues impacting MCH health status.

An epidemiological investigation was conducted in response to an inquiry regarding a suspected cluster of fetal and infant deaths in the St. Charles County, Missouri, during the 2003 year. This evaluation showed no evidence of an elevated fetal or infant mortality rate, regarding the temporal distribution of rates, the percent contribution of pregnancies with multiples, and potential environmental risks. While there were no statistically significant increases in St. Charles County regarding infant mortality, in 2003, pregnancies with multiples provided a higher contribution to the overall infant mortality rate than the following year (although not significantly different than the state as a whole). The greatly diverse causes of death indicated that a variety of causes and risk factors, rather than a single environmental exposure, contributed to the fetal and infant deaths.

OOE assisted in the identification of and prioritization of MCH-related health problems and health risk behaviors for infants, children, adolescents and women of childbearing age using the Priority MICA, an interactive web-based data system. The priority areas were ranked according to severity and risk for Missouri's population based on death trend, number of deaths, racial disparity for deaths, hospital days of care, number of hospitalizations and emergency department visits, disability burden, amenability to change and community support.

/2009/
In 2008, 41 LPHA contractors are addressing injury prevention among this population through an

improved coordinated system and based on interventions that are evidence-based, field tested or validated by expert opinion.
//2009//

//2010//
In 2009, 41 LPHA contractors continue to address injury prevention among this population through an improved coordinated system and based on interventions that are evidence based, field tested or validated by expert opinion.
//2010//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	payment source from birth certificate	76.2	91.2	83.8

Narrative:
--Baby Your Baby Web site (www.dhss.mo.gov/babyyourbaby) has information for pregnant women, their families and communities on healthy pregnancies and healthy babies. Topics and links include prenatal care and nutrition, MC+ (Medicaid), WIC, and TEL-LINK that is a toll free information and referral line.

--Campaign ads were developed with the Missouri Broadcaster's Association for messages to promote healthy pregnancy through early and adequate prenatal care. Ads promote the importance of the family history to identify health problems that run in the family which can help doctors better determine the risk of disease among their patients and help motivate them into action to stay healthy.

--The WIC Program prescribes and pays for nutritious foods to supplement the diets of pregnant women, new mothers, infants and children up to five years of age, who qualify as "nutritionally at risk," based on a medical and nutrition assessment and state income and federal poverty guidelines. The WIC Program provides various assistance including medical referrals to health care providers to address the WIC participants needs.

--MCH Coordinated Systems Contracts with LPHAs-Title V funds support LPHAs for the purpose of establishing and maintaining a system capable of addressing adequate prenatal care. Two performance measures were addressed in jurisdictions where the data was most disparate:
-Increase the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester (11 LPHAs); and
-Decrease the percent of pregnant women receiving inadequate prenatal care (13 LPHAs).

/2009/
In 2008 contracts with LPHAs have been renewed with the focus on the objectives on injury prevention, obesity and tobacco. Local contractors may continue to address the issue of adequate prenatal care within their communities.

//2009//

/2010/
In 2009 contracts with LPHAs continue with the focus on injury, obesity and tobacco prevention. Local contractors may also address the issue of adequate prenatal care within their communities.
//2010//

--Healthy Babies-This initiative provides educational materials through the Web site and printed materials in English and Spanish that promote healthy pregnancies and healthy birth outcomes and encourages early entry into prenatal care. The Web site (www.dhss.mo.gov/babyyourbaby) will be active through January 2008.

/2009/
This contract has been renewed through January 2013.
//2009//

--Home Visiting-Funds are allocated to MCBHV and Building Blocks of Missouri to provide home visiting services for high-risk pregnant women and infants at risk of infant mortality or morbidity and abuse or neglect. In 2005 the program was expanded to the St. Louis City/County region through a contract with the St. Louis County Health Department.

--Genetic Services-Title V partially funds the program's contributions in the reduction of morbidity and mortality associated with genetic disorder. The genetic disease program maintains a referral network that connects Missourians in need of diagnostic treatment, counseling and specialized health services with appropriate health care providers.

--FIMR Development-Funds will continue to be used in supporting and expanding existing FIMR boards/projects in local communities to examine the causes of fetal and infant deaths not examined by the Child Fatality Review Board and to recommend policy, program or systems changes which may reduce the rate of fetal infant mortality and possibly encourage prenatal care in first trimester.

--Epidemiological Services-Title V funds will be used to fund epidemiological consultation services regarding needs assessment and evaluation of maternal and child health (MCH) programs and to provide technical assistance to identify factors that affect infant mortality, injury prevention and other issues impacting MCH health status.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to	2008	payment source from birth certificate	66.6	81.8	74.3

80% [Kotelchuck Index])					

Narrative:
--Baby Your Baby Web site (www.dhss.mo.gov/babyyourbaby) has information for pregnant women, their families and communities on healthy pregnancies and healthy babies. Topics and links include prenatal care and nutrition, MC+ (Medicaid), WIC, and TEL-LINK that is a toll free information and referral line.

--Campaign ads were developed with the Missouri Broadcaster's Association for messages to promote healthy pregnancy through early and adequate prenatal care. Ads promote the importance of the family history to identify health problems that run in the family which can help doctors better determine the risk of disease among their patients and help motivate them into action to stay healthy.

--The WIC Program prescribes and pays for nutritious foods to supplement the diets of pregnant women, new mothers, infants and children up to five years of age, who qualify as "nutritionally at risk," based on a medical and nutrition assessment and state income and federal poverty guidelines. The WIC Program provides various assistance including medical referrals to health care providers to address the WIC participants needs.

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-Increase the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester (11 LPHAs); and
-Decrease the percent of pregnant women receiving inadequate prenatal care (13 LPHAs).

/2009/
In 2008 contracts with LPHAs have been renewed with the focus on the objectives on injury prevention, obesity and tobacco. Local contractors may continue to address the issue of adequate prenatal care within their communities.
//2009//

/2010/
In 2009 contracts with LPHAs continue with the focus on injury, obesity and tobacco prevention. Local contractors may also address the issue of adequate prenatal care within their communities.
//2010//

--Healthy Babies-This initiative provides educational materials through the Web site and printed materials in English and Spanish that promote healthy pregnancies and healthy birth outcomes and encourages early entry into prenatal care. The Web site (www.dhss.mo.gov/babyyourbaby) will be active through January 2008.

/2009/
This contract has been renewed through January 2013.
//2009//

--Home Visiting-Funds are allocated to MCBHV and Building Blocks of Missouri to provide home visiting services for high-risk pregnant women and infants at risk of infant mortality or morbidity and abuse or neglect. In 2005 the program was expanded to the St. Louis City/County region through a contract with the St. Louis County Health Department.

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health services with appropriate health care providers.

--FIMR Development-Funds will continue to be used in supporting and expanding existing FIMR boards/projects in local communities to examine the causes of fetal and infant deaths not examined by the Child Fatality Review Board and to recommend policy, program or systems changes which may reduce the rate of fetal infant mortality.

--Epidemiological Services-Title V funds will be used to fund epidemiological consultation services regarding needs assessment and evaluation of maternal and child health (MCH) programs and to provide technical assistance to identify factors that affect infant mortality, injury prevention and other issues impacting MCH health status.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	300

Narrative:
--October 2003, DHSS was awarded the State Planning Grant from the federal Department of Health and Human Services (HHS) to allow the state to study the issue of the uninsured and to develop a state plan with models and options for increasing access to affordable health insurance coverage for MO residents.

Subsequent to the award of this planning grant, the DHSS/DCPH through a contract with the University of Missouri carried out the Missouri Health Care Insurance and Access Survey that was funded with this grant. The survey of 7,000 households conducted in 2004, revealed that about 8.4% of Missouri residents did not have health insurance at the time of the survey. This percentage reflected almost 463,000 Missourians not covered by health insurance. This survey also revealed that about 64,000 of those without health insurance were primarily children whose families earn 300 percent or less of the federal poverty level and parents who earn 75 percent of less of the poverty level who are eligible for insurance coverage but who for whatever reasons are not accessing that insurance coverage.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2008	 133 100

INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2008	 300 300

Narrative:
--October 2003, DHSS was awarded the State Planning Grant from the federal Department of Health and Human Services (HHS) to allow the state to study the issue of the uninsured and to develop a state plan with models and options for increasing access to affordable health insurance coverage for MO residents.

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--Coordination and Systems Development-Title V funds are used to support staff in DCPH to carry out activities related to assessment, policy and program development, quality assurance, contract monitoring and program implementation and coordination. Coordination activities between state and local agencies and data collection, analysis and data processing services are also supported with this funding.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	185

Narrative:
--October 2003, DHSS was awarded the State Planning Grant from the federal Department of Health and Human Services (HHS) to allow the state to study the issue of the uninsured and to develop a state plan with models and options for increasing access to affordable health insurance coverage for MO residents.

Subsequent to the award of this planning grant, the DHSS/DCPH through a contract with the University of Missouri carried out the Missouri Health Care Insurance and Access Survey that was funded with this grant. The survey of 7,000 households conducted in 2004, revealed that

about 8.4% of Missouri residents did not have health insurance at the time of the survey. This percentage reflected almost 463,000 Missourians not covered by health insurance. This survey also revealed that about 64,000 of those without health insurance were primarily children whose families earn 300 percent or less of the federal poverty level and parents who earn 75 percent of less of the poverty level who are eligible for insurance coverage but who for whatever reasons are not accessing that insurance coverage.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	No
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	No
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	2	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	2	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:
--The current State Systems Development and Initiative (SSDI) cycle has supported a pilot PRAMS, Missouri Pregnancy Related Assessment and Monitoring System (MoPRA), survey for Missouri. The successful completion of this pilot project has resulted in funding from CDC to support a PRAMS surveillance system in Missouri. PRAMS data (related to attitudes and expectations of mothers who have delivered in last six months) will provide crucial information in formulating MCH program access policy for State of Missouri (HSCI 9A).

--BHI is primary source for health data within the state. BHI oversees the statistical support and health care assurance activities of DHSS; collects, analyzes and distributes health-related information which promotes better understanding of health problems and needs in Missouri; and highlights improvements and progress achieved in the general health status of Missourians. To assure uniform and consistent reporting of all Title V related data, DCPH Director's Office works with ITSD to integrate the eleven core health systems capacity indicators and some of the health status indicators into MOHSAIC.

DHSS Web pages provide access to MCH data through the Community Data Profiles and MICA system. The Community Data Profiles are resource pages that provide information on specific MCH indicators, including a definition of the indicator, risk factors, description of the condition, intervention strategies, state-related programs, community programs and resources, contracts and grants, educational material, studies and reports and other Web sites pertaining to the MCH indicator.

DCPH/ITSD provides continued integration of multiple single purpose databases into a single system which supports a child-centered record. The initial child record is created from birth records for children born in Missouri. DCPH/ITSD supports documentation of services received and/or results of screenings for the child. The system also includes data on immunizations, tuberculosis skin testing, Medicaid status, results of newborn blood spot, newborn hearing screenings results and blood lead level.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No
Pediatric Nutrition Surveillance System(PedNSS)	3	Yes
WIC Program data	3	Yes
Pregnancy Risk Assessment Monitoring System (PRAMS)	3	Yes

Notes - 2010

Narrative:
--Tobacco use among public high school students in Missouri is monitored through the Youth Risk Behavior Survey conducted every odd numbered spring since 1995 by DESE and funded by the CDC Division of Adolescent and School Health. DHSS Tobacco Use Prevention Program conducted for the first time the Youth Tobacco Survey in 2003 with public middle and high school students, funded by CDC Office on Smoking and Health. Results are in a fact sheet on DHSS Web site, www.dhss.mo.gov/SmokingAndTobacco/youth_use.html.

The Youth Tobacco Survey was also conducted in 2005 and results are on the Web site given above.

/2008/
Missouri consistently ranks among the highest in the nation in adult and youth smoking prevalence. Among adults, 23.4% smoked in 2005, which was eleventh highest among all States (CDC, BRFSS, 2005). Among youth, 8.3% of middle school and 23.7% of high school students were current smokers in 2005, both slightly above the national average. (DHSS, Youth Tobacco

Survey, 2003) Additionally, over one third (35.4%) of middle school students and almost two thirds (62.8%) of high school students have used some form of tobacco product in their lifetime. According to the MoPRA survey conducted by DHSS during 2004-2006, 20.4% of mothers smoked during the last three months of their pregnancy.
//2008//

--MCH Coordinated Systems Contracts with LPHAs --Many community-based interventions will be focused on youth tobacco prevention.

/2008/
In 2007, 51 LPHA contractors are working to reduce smoking or prevention smoking initiation through the MCH Coordinated Systems contracts.

In 2008, the MCH Coordinated Systems contracts with LPHAs will be renewed with one of the focus areas as preventing tobacco use among adolescents and women. Each contractor will have a contractual obligation to utilize evidence-based interventions. Local system development to address smoking prevention will include community-based interventions and environmental and policy changes to impact the initiation and cessation of smoking in this population.
//2008//

/2009/
In 2008, 23 LPHA contractors are addressing tobacco prevention/cessation among this population through an improved coordinated system and based on interventions that are evidence-based, field tested or validated by expert opinion.

CCHC Program reports 14 hours of training to child care providers on the risks/dangers of smoking/second hand smoke and 24 health promotion programs to young children on the same topic in FFY 2007.
//2009//

/2010/
In 2009, 23 LPHA contractors continue to address tobacco prevention/cessation among this population through an improved coordinated system and based on interventions that are evidence-based, field tested or validated by expert opinion.

CCHC Program reports 6 hours of training to child care providers on the risks/dangers of smoking/second hand smoke and 22 health promotion programs to young children on the same topic in FFY 2008.
//2010//

--Adolescent Health Projects-Title V funding supports the development and implementation of state and community-based projects to promote adolescent health. The Missouri Council for Adolescent and School Health (CASH) advises the department on priorities for adolescent health initiatives. The Council's priority recommendations for potential funding include projects to more comprehensively address adolescent health through positive youth development and evidence-based strategies. Another statewide strategy is adolescent medicine consultation. Provider education is accomplished through the publication and dissemination of a bimonthly newsletter sent to pediatricians, family practice physicians, advanced practice nurses and school nurses. Newsletter articles cover a wide range of adolescent health concerns.

In 2005, CASH developed the MISSOURI STATE FRAMEWORK FOR PROMOTING THE HEALTH OF ADOLESCENTS that sets forth guiding principles relevant and applicable to any health issue that impacts the health of adolescents and supports the HEALTHY PEOPLE 2010 NATIONAL INITIATIVE TO IMPROVE THE HEALTH OF ADOLESCENTS AND YOUNG ADULTS. MCH block grant funding will also support the implementation of the quality improvement plan that will be based on priority needs identified through the SYSTEM CAPACITY

ADOLESCENT HEALTH ASSESSMENT and planning process conducted in January 2006.

/2009/
A DHSS Adolescent Health Leadership Team has been established and merged with CASH to address priority needs identified through the ADOLESCENT HEALTH SYSTEM CAPACITY ASSESSMENT. MCH block grant funding supports the implementation of the quality improvement plan.
//2009//

/2010/
A DHSS Adolescent Health Team merged with CASH to address adolescent health priority needs, including youth tobacco use prevention. The Adolescent Health Program and Bureau of Health Promotion collaborative efforts include youth strategies in LPHA contracts to promote primary prevention of chronic disease, Smoke Busters, and other strategies at Missouri's first Smoke-Free Youth Summit.

Contractors (186 serving 283 schools) in the School Health Program used the CDC School Health Index to assess their school environment for policies and practices related to physical activity, nutrition practices and tobacco use, 22 school districts chose goals related to tobacco.
//2010//

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Missouri Title V Block Grant Performance Measurement System schematic follows the MCHB system approach that begins with the needs assessment and identification of priorities and culminates in improved outcomes for the Title V population. Like other states receiving Title V MCH Block Grant funding, Missouri must meet the following requirements:

-Conduct a statewide needs assessment every five years that identifies the need for:
---Preventive and primary care services for pregnant women, mothers and infants up to age one year;
---Preventive and primary services for children;
---Family-centered, community-based services for children with special health care needs and their families; and
---Review of data and sources of information used to construct the needs assessment.

-For each fiscal year, Missouri and other Title V funded states, will:
---Describe how Title V funds allotted to the State will be used for the provision and coordination of MCH services;
---Assure "maintenance of effort" (i.e., State will maintain the level of funds being provided solely by such State for maternal and child health programs at a level at least equal to the level provided in FFY 1989);
---Use at least 30 percent of Federal MCH Block funds received for preventive and primary care services for children; and
---At least 30 percent of Federal MCH Block Grant funds received for services for children with special health care needs.

Accountability for Title V MCH Block Grant funding awarded, is also achieved through:
-Measuring the progress towards successful achievement of each individual performance measure;
-Having budgeted and expended dollars spread over all four of the recognized MCH services: direct health care, enabling services, population-based services and infrastructure building services and;
-Having a positive impact on MCH outcome measures.

Missouri's priority needs are discussed in Section II, Needs Assessment (5. Selection of State Priority Needs) and Section IV. B, State Priorities. National and State Performance measures are examined in Section II as well as in Section IV. C and D.

/2007/
For the entire 2005 Needs Assessment, go to:
https://perfdata.hrsa.gov/mchb/mchreports/documents/NeedsAssessments/2006/MO-NeedsAssessment.pdf

Section II of this 2007 application/2005 report has an attachment with an update to the matrix of the comparison of the performance measures, health systems capacity indicators and state priorities that was included in the Needs Assessment.
//2007//

The MCH pyramid of "Core Public Health Services Delivered by MCH Agencies" by levels of service serves as a guide for the Missouri pyramid of services.

The two pyramids and the lists of Missouri's 10 priority needs, the 6 mandated national outcome measures, the 18 national performance (NP) measures and the state performance (SP) measures are in the document attached to this Section IV. A. The file also contains a listing of the

Health Systems Capacity Indicators (HSCIs) and Health Status Indicators (HSI).

The NP and SP measures are also listed in Tables 4a and 4b that identify the specific pyramid level of service and the key activities for each.

The NP measures are examined in Section IV. C. Also, Form 11 has the report on Missouri's status relative to the 18 NP measures and Missouri's five-year objectives relative to each of these. See Section VII for the NP and SP measure detail sheets.

In FFY 2005, DHSS/DCH completed a five-year MCH needs assessment identifying the need(s)for:
-Preventive and primary care services for pregnant women, mothers and infants;
-Preventive and primary care services for children; and
-Services for children with special health care needs (CSHCN).

This assessment included but was not limited to the following methods:
-Review of Missouri state profiles compiled by HRSA, CDC and AMCHP to ascertain external perspectives of MCH needs in Missouri;
-Qualitative primary data generated through 12 focus groups conducted throughout Missouri divided into client (user) group and provider or agency group;
-Review of CHART survey of local coalition members, state and county profiles (with selected MCH indicators and related priorities) generated by the CHIME and local public health priorities formulated by the CLPHS;
-MCH population group(s) forecasts developed from demographic data drawn from the U.S. Census and from analysis provided by the Missouri State Demographer's Office;
-A composite analysis of selected MCH indicators to compare (county by county) the relative MCH health status of women and children living in different geographical regions in Missouri: infant mortality; unintended pregnancies (teenage pregnancies); tobacco use among mothers during pregnancy; STDs among women of childbearing age; abortions; obesity; percentage of MCH population groups with insurance coverage;
-Data provided by the DSS, DMH, MPCA and other professional associations concerning the infrastructure capacity (in Missouri) to deliver basic health services to MCH population groups;
-Nominal group process used by selected MCH stakeholders to suggest possible MCH priorities for Missouri; stakeholders reviewed a draft version of the assessment presented in this application, reflected upon their own experiences and developed a ranking of needs that captured the collective thinking of the group; and
-An MCH priority setting methodology developed by the Office of Epidemiology and CHIME (MICA priorities) was constructed and applied to data collected for MCH population groups in Missouri.

See Section II, Needs Assessment, for further details.

See Table 4b in D. State Performance Measures of Section IV Priorities, Performance and Program Activities and Form 16, State Performance Measure Detail Sheets, for descriptions of the state selected measures that includes their category on the pyramid, the Missouri goal, the measure used, how the measure is defined, the measure's relationship to Healthy People 2010 (if applicable), data sources and data issues and the significance of the indicator or why this particular indicator was chosen.

An attachment is included in this section.

B. State Priorities

B.1. RELATIONSHIP AMONG PRIORITIES, PERFORMANCE MEASURES and HEALTH SYSTEMS CAPACITY INDICATORS

MO is transitioning from MCH resources (including MCH block funding) now supporting MCH priority needs identified in 2000 to realigning MCH resources to support MCH priority needs identified in MO MCH Five Year Needs Assessment.

2000 MCH Priority Needs
--Healthcare Access
--Prevention of Smoking Among Children and Adolescents
--Reduction of Unintended Pregnancies
--Reduction of Child Abuse and Neglect
--Minority Health Disparities
--Expanded MCH Information Systems

2005 MCH Priority Needs
--Early Childhood Development and Education
--Improve Access to Care
--Reduce and Prevent Oral Health Conditions
--Improve Mental Health Status of MCH Population
--Reduce Obesity Among Children, Adolescents and Women
--Reduce Disparities in Birth Outcomes
--Prevent and Reduce Smoking
--Reduce Intentional and Unintentional Injuries
--Enhance Environmental Supports/Policy Development for Prevention of Chronic Disease
--Reduce Interpersonal/Domestic Violence in MCH Populations

MO 2005 MCH Five Year Needs Assessment details state MCH capacity available to support newly identified MCH priorities which will establish framework for allocation of Title V MCH funding for priority need areas not already receiving adequate support, such as early childhood development, prevention of smoking and reduction of obesity. Overriding MCH need for Missouri was to improve access to care.

B.2. DIRECT SERVICES AND ENABLING SERVICES

DHSS is addressing access to care and reduction and prevention of oral health conditions through OPCRH to ensure access to primary health care services for all populations.

/2009/
PSP provides oral health surveillance, education and preventive services to children under 18, through community-based system of care including representation of all aspects of community and health care delivery system. Core components include community governance coalition, dental referral system, standardized screening/surveillance methodology and provision to participating communities of fluoride varnish, screening forms and supplies, data analysis and oral health educational materials.
//2009//

Access to health care services in MO is contingent on more than adequate health insurance. Health insurance plans or managed care plans provide "paper benefits" and must be coupled with adequate supply of qualified health practitioners in all regions and infrastructures to reduce geographical or cultural barriers. Some barriers are due to lack of resources, such as community clinics, medical equipment and practitioners and to disparity of health resources in underserved areas.

DHSS/DCH, through UM contract, carried out in 2004 Missouri Health Care Insurance and Access Survey of 7,000 households, showed:
-about 8.4% (almost 463,000) did not have health insurance at time of survey
-about 64,000 without health insurance were primarily children whose families earn 300% or less of FPL and parents who earn 75 % or less of poverty level who are eligible for insurance

coverage but who are not accessing insurance coverage.

Outside of I-70 corridor, 68% of MO counties are not covered by Medicaid managed care plans and many have few if any practitioners who accept Medicaid.

93% MO counties are designated as Health Professional Shortage Areas (HPSA) for primary medical care services.

33.9% have FQHCs in operation that can serve persons with no insurance or who live in area with providers that will not accept Medicaid.

85% are designated as Dental HPSAs.

/2007/
See MC+ Managed Care Web site.
//2007//

/2009/
For MO HealthNet Managed Care (formerly MC+ Managed Care) see http://www.dss.mo.gov/mhd/mc/index.htm
//2009//

Based on information from Child and Adolescent Health Measure Initiative, Data Resource Center on Children and Youth with Special Health Care Needs, December 2004, Missouri reported dental care (9.8%), mental health care (13.6%) and specialist care (7.0%) as needed by CSHCN but did not received.

/2009/
According to NSCSHCN 2005-06, of CSHCN in MO who needed specific health care services, but did not receive all the care they needed accounted for 10% for preventive dental care, 9.3% for mental health care, and 3.8% for specialist care.
//2009//

Based on unweighted estimates from Behavioral Risk Factors Surveillance System (BRFSS), 2004:
--6.7% of MO households with children reported having one or more children under 5 currently has asthma
--12.8% of households with children reported having one or more children 5 to 17 years of age currently has asthma.

American Academy of Allergy, Asthma and Immunology and Asthma and Allergy Foundation of America ranked 100 largest metropolitan areas by asthma severity based on prevalence, risk factors and medical factors. St. Louis was ranked 3rd; Kansas City 8th.

/2009/
Based on National Survey of Children's Health in 2003 of MO's children:
--11.5% under 18 ever had doctor-diagnosed asthma, compared with 12.1% nationwide
--among those ever having asthma, 68.7% experienced one or more asthma-related health issue in past 12 months, compared with 66.9% nationwide.

Lifetime asthma prevalence among MO children increased by age:
--7.8% for 0-5 years
--11.5% for 6-11 years
--14.9% for 12-17 years

According to MO BRFSS conducted in 2006, estimated 15.9% lifetime and 11.7% current asthma

prevalence was among children under 18.
NOTE: Childhood asthma prevalence for 2003 and 2006 were obtained from two different data systems and may not be comparable.
//2009//

/2010/
Under 18, 13.1% ever had & 8.6% currently had asthma.(BRFSS 2007)

Corrected 2006-13.4% ever had & 9.5% currently had asthma.
//2010//

Among enabling programs to address issues are home visiting, CSHCN Hope Program, WIC, CSHCN Service Coordination, FP and HCY.

B.3. POPULATION-BASED SERVICES

Interpersonal/Domestic violence (DV) against women affects all economic, educational, cultural, racial and religious lines. In 2000, 37,898 DM cases were reported to MO law enforcement; 50 of 88 women murdered were attributed to DV. In 2001 of female high school students, 10% reported having been forced to have sexual intercourse; almost 9% reported being hit, slapped or physically hurt on purpose by their boyfriend in past 12 months.

/2007/
DV cases reported to law enforcement in 2004 totaled 39,097 with 51 DV homicides in 2004. Per 2003 YRBS, 13.1% high school girls reported having been forced to have sexual intercourse. 8.5% high school students reported being hit, slapped, or physically hurt on purpose by a boyfriend or girlfriend in past 12 months.
//2007//

/2008/
In 2005 in MO:
--39,851 DV cases were reported to law enforcement, 6.9 per 1,000 residents (slightly up from 6.8 cases per 1,000 in 2000) (Missouri Uniform Crime Reporting Statistics)
--estimated 10.9% female high school students (14,617 students) reported having been forced to have sexual intercourse
--estimated 8.3% female high school students (11,209 students) reported being hit, slapped or physically hurt on purpose by their boyfriend in past 12 months (CDC, YRBS 2005).
//2008//

/2009/
In 2007 in MO:
--37,215 DV cases were reported to law enforcement, 6.4 per 1,000 residents (Missouri Uniform Crime Reporting Statistics)
--14% females and 6.6% males reported ever having been physically forced to have sex
--9% female and 12% male high school students reported being hit, slapped or physically hurt on purpose by their boyfriend or girlfriend in past 12 months (CDC, YRBS 2007 survey of 1,561 students in 23 Missouri public high schools in grades 9-12.)
//2009//

/2010/
34,178 DV cases (5.9/1,000)(MOUCRS 2008)
//2010//

Reduction and prevention of smoking is priority in MO which is ranked 10th in 2003 out of 31 states participating in YRBS that included question regarding smoking cigarettes on 1 or more days in past 30 days in 2003. Missouri 2003 Youth Tobacco Survey conducted by DHSS June

2003, determined 43.5% middle school students and 65.8% high school students have used some form of tobacco product in their lifetime. Smoking among pregnant females aged 15-19 was 27.2% in 2001-2002 and overall smoking during pregnancy ranked Missouri 8th highest among all states.

/2007/
MO consistently ranks among highest in nation in adult and youth smoking prevalence. Among adults, 23.4% smoked in 2005 which was 11th highest among all states (CDC, BRFSS, 2005). Among youth, 8.3% middle school and 23.7% high school students were current smokers in 2005, both slightly above national average. (DHSS, Youth Tobacco Survey, 2003)

35.4% middle school students and 62.8% high school students have used some form of tobacco product in their lifetime.

There is no statistical difference between MO teenagers who smoked during pregnancy in 1995 and 2004.
//2007//

/2008/
According to MoPRA survey conducted by DHSS during 2004-2006, 20.4% mothers smoked during last 3 months of pregnancy.

In 2007, MCH Coordinated Systems contracts have 51 LPHA contractors working on community-based initiatives related to smoking prevention or cessation.

In 2008, MCH Coordinated Systems contracts with LPHAs will be renewed with one of the focus areas as preventing tobacco use among adolescents and women. Each contractor will have contractual obligation to utilize evidence-based interventions. Local system development to address smoking prevention will include community-based interventions and environmental and policy changes to impact initiation and cessation of smoking in this population.
//2008//

/2009/
MO consistently ranks among highest in nation in adult smoking prevalence. Among adults, 23.2% were current smokers in 2006, 11th highest among all states (CDC, BRFSS, 2006).

34.6% middle school students and 58.9% high school students have used some form of tobacco product in their lifetime.

According to YRBS, smoking prevalence among MO high-school students steadily declined from 40.3% in 1997 to 21.3% in 2005 though slightly increased to 23.8% in 2007. Smoking prevalence in MO in 2005 (most recent data available for both MO and U.S.) was slightly lower than national figure (21.3% vs. 23%).

There has been steady decline in smoking prevalence from 14.9% in 1999 to 6.9% in 2007 based on DHSS Youth Tobacco Survey conducted of middle school students,

CCHC provided in FFY 2007 14 hours of adult education on risks of smoking/second hand smoke and 24 health promotion programs to young children on risks of smoking/second hand smoke.
//2009//

/2010/
24.5% of adults currently smoked, 4th highest in nation(BRFSS 2007).

34.6% middle school youth & 58.9% high school youth ever used a tobacco product. Decline in smoking 14.9% in 1999 to 6.9% in 2007 in middle school youth(MOYTS 2007).

PRAMS 2007, 18.4% smoked in last 3 months of pregnancy.
//2010//

Reduction in obesity among children, adolescents and women is a priority. In 2002 overweight rate for children 2-5 years participating in WIC was 12%, 18th highest overweight level in nation. Data from MO School-Age Children Health Service Program for 5th graders show 18.5% are overweight. Prevalence of overweight in children in grades 6-8 was 15.9% in 2003, up from 9.1% in 1999. In 2002 prevalence of overweight high school students was 12%. During last 10 years, obesity rate among pregnant women in Missouri has increased from 13.8% in 1993 to 21.3% in 2003.

/2007/
MO Facts About Overweight among Missouri Children and Adolescents
--12.0% of children participating in WIC are overweight (CDC. 2003. PedNSS Reports.)
--22.8% of elementary school students participating in Missouri School-aged Children Health Service Program are overweight (Missouri Department of Health and Senior Services. Dietary Intake and Physical Activity Summary Report. MO School-Age Children's Health Services Program School Year 2002-2003.)
--14.5% of middle school students are overweight
--13.6% of high school students are overweight
(Missouri Department of Health and Senior Services. 2005. Youth Tobacco Survey.)

Obesity rate among pregnant women in MO increased from 14.6% in 1994 to15.4% in 1995; and from 22.2% in 2004 to provisional 2005 rate of 22.4%.
//2007//

/2008/
--13.8% of children aged 2-5 years participating in WIC are overweight
(PedNSS Reports, 2004.)
--13.9% (±2.4%) of high school students are overweight (CDC, YRBS 2005.)

Overweight rate among pregnant women increased from 35.2% in 2000 to 38.5% in 2005 (Birth MICA).

/2009/
--13.6% of children aged 2-5 years participating in WIC are overweight (PedNSS Reports, 2006.)

Prevalence of overweight in MO in 2007 was 11.9% among middle school students and 12.3% among high school students (DHSS, Youth Tobacco Survey, 2007.)

Overweight rate among pregnant women has increased from 35.2% in 2000 to 39.0% in 2006 (Birth MICA).
//2009//

In 2007 14 MCH coordinated system contracts related to youth obesity prevention with community interventions aimed at preschool through middle schools students and prenatal WIC clients.

In 2008 MCH Coordinated Systems contracts with LPHAs will be renewed with one of the focus areas to reduce obesity in MCH population.
//2008//

/2009/
In 2008, 48 LPHAs are addressing reducing obesity in MCH populations.

In FFY2007 CCHC delivered obesity prevention education through 293 hours of group education on socializing healthy nutritional habits in young children to 1,827 child care providers and young parents and 256 hours of group education on socializing healthy physical activity habits in young children to 1,472 child care providers and young parents. 23 hours on-site consultation and 336 health promotion programs to young children on same topics were provided.
//2009//

/2010/
13.7% of 2-5 years olds in WIC are overweight(PedNSS 2007.)

11.9% middle school youth & 12.3% high school youth were overweight(MOYTS 2007.)

Prepregnancy overweight increased from 35.2% in 2000 to 39.3% in 2007(Birth MICA).

FFY2008 CCHC held obesity education for child care provides/parents through 190 hours on socializing healthy nutritional habits to 1,116 recipients, 212 hours on basic nutrition to 1,393 recipients and 82 hours on supporting breastfeeding families in child care to 612 recipients. Provided 9 hours on-site consultation and 306 health promotion programs to children.
//2010//

-Reduction in disparities in birth outcomes is included as a priority due to disparities between African-Americans and whites.

Neonatal death rate per 1,000:
African-American: 10.8; White: 4.1

Pre-term birth rate per 1,000:
African-American: 17.4; White: 9.5

Low birth weight rate per 1,000:
African-American: 13.3; White: 6.8
(DHSS Community Data Profiles, 2000-2002)

/2007/
For 2004:

Neonatal death rate (Birth MICA and Vital Statistics):
African-American: 9.1; White: 4.2

Pre-term birth rate (Birth MICA):
African-American: 20.2; White: 12.1

Low birth weight rate (Birth MICA):
African-American: 14.0; White: 7.3
//2007//

/2008/
For 2005:

Neonatal death rate per 1,000 live births (Birth MICA and Vital Statistics):
African-American: 9.5; White: 3.9

Pre-term birth rate per 100 (Birth MICA):
African-American: 20.5; White: 12.5

Low birth weight rate per 100 (Birth MICA):
African-American: 14.4; White: 7.0
//2008//

/2009/
For 2006:
Neonatal death rate per 1,000 live births (Birth MICA and Vital Statistics):
African-American: 10.1; White: 3.9

Pre-term birth rate per 100 (Birth MICA):
African-American: 19.3; White: 12.0

Low birth weight rate per 100 (Birth MICA):
African-American: 13.6; White: 7.1
//2009//

/2010/
2007(Birth MICA and Vital Statistics):
Neonatal death per 1,000 live births:
African-American: 11.6; White: 3.8

Pre-term birth per 100:
African-American: 19.2; White: 11.8

Low birth weight per 100:
African-American: 13.5; White: 6.9
//2010//

Based on MO Child Abuse and Neglect (CA/N) Calendar Year 2003 Annual Report, number of children reported as victims of child abuse or neglect in 2003 was 54,581 in 35,452 reported incidents. Of 9,712 confirmed as abused or neglected, neglect accounted for 44.9%; physical abuse 24.5%; and sexual abuse 23.9%. 37.5% of abused and neglected children were under 6. Of abused and neglected fatalities, 80% were under 6.

/2007/
2004 total hotline reports of child abuse:
--56,169 reports involving 85,133 children
--9,262 cases of substantiated abuse of which 47.1% were neglect; 25.2% physical abuse; and 22.7% sexual abuse
--73.2% of fatal child abuse occurred to children under 6
--36.7% of non fatal child abuse occurred to children under 6
--87.5% of child abuse were perpetrated by somebody known to the child
--12.5% were stranger abuse
//2007//

/2008/
Based on CA/N Calendar Year 2005 Annual Report, children reported as victims of child abuse or neglect in 2005 was 80,577 in 54,108 reported incidents. Of 8,158 confirmed as abused or neglected, neglect accounted for 47.9%; physical abuse 25.8%; and sexual abuse 24.1%.

Among victims of abuse and neglect 36.3% were less than 6. Of 32 abuse and neglect fatalities, 81.3% were under 6.

NOTE from Report: All counts of children are duplicated because a child may be reported more than once during the year.
//2008//

/2009/
Based on CA/N Calendar Year 2006 Annual Report, children reported as victims of child abuse or neglect in 2006 was 75,474 in 51,383 reported incidents. Of the 7,222 confirmed as abused or neglected, neglect accounted for 41.5%; physical abuse 31.2%; and sexual abuse 22.4%.

Among victims of abuse and neglect, 35.3% were less than 6. Of 27 abuse and neglect fatalities, 81.5% were under 6.

NOTE from Report: Counts of children are duplicated because a child may be reported more than once during the year

FFY 2007 CCHC delivered 38 hours of training to child care providers on recognition and prevention of child abuse. 55 programs were provided to young children on prevention of child abuse.
//2009//

/2010/
CAN 2007, reported 77,481 victims of child abuse or neglect. Of the 6,576 confirmed, 50% neglect; 29.1% physical abuse; and 26.6% sexual abuse.

38.6% of 6,576 and 78.3% of 46 fatalities were under 6.

FFY 2008 CCHC held 54 training hours for child care providers on child abuse. 90 programs provided to children.
//2010//

Based on DHSS "Injuries in Missouri: A Call to Action", December 2002, Missouri exceeded U.S. average in 3 of 5 leading causes of premature death among MCH populations: motor vehicle-related fatalities; suicides; and deaths caused by firearms. In 1998 15-19 year olds had high rate of death due to motor vehicle accidents. Death rate among 15-24 year olds due to motor vehicle accidents in 2003 was 37.3 per 100,000, DHSS MICA.

/2007/
2004 rates for unintentional motor vehicle injuries and deaths for 15-24 year olds:
--224.5//100,000 population for injuries related to non-fatal motor vehicle traffic crashes
--37.5/100,0000 were deaths from motor vehicle crashes.
//2007//

/2008/
2005 rates for unintentional motor vehicle injuries and deaths for 15-24 year olds:
--215.4/100,000 injury hospitalizations related to non-fatal motor vehicle traffic crashes
--40.6/100,000 deaths from motor vehicle crashes.
//2008//

/2009/
2006 rates for unintentional motor vehicle injuries and deaths for 15-24 year olds:
--213 per 100,000 injury hospitalizations related to non-fatal motor vehicle traffic crashes
--36.1/100,000 deaths from motor vehicle crashes
(Injury MICA and Death MICA).

FFY 2007 CCHC provided 21 hours of group education to child care providers on child passenger safety; 50 hours on injury prevention in child care; 91 hours on emergency preparedness; 18 hours on poison prevention; and 14 hours on safe sleep. 283 programs were provided to young children on injury prevention topics.
//2009//

/2010/
2007 rates for unintentional motor vehicle injuries and deaths for 15-24 year olds:
-21.8/100,000 injury hospitalizations due to non-fatal mvc (provisional)
-30.7/100,000 deaths from mvc
(BHI Inpatient Data and Death MICA).

FFY 2008 CCHC held 20 education hours for child care providers on child passenger safety; 56 hours on injury prevention in child care; 77 hours on emergency preparedness; 10 hours on poison prevention; and 16 hours on safe sleep. 467 programs provided to children.
//2010//

Priorities are being addressed by programs such as Injury and Violence Prevention, MCH (Local Agency) Services, School Health, Nutrition and Obesity Education and Folic Acid and Healthy Babies Education.

/2009/
Also, Adolescent Health Program, and Missouri Department of Transportation Traffic Safety Youth Committee and partners.
//2009//

/2007/
Through contracts with state and community-based initiatives, LPHAs provide array of population-based services to help address many of these priority need areas.
//2007//

/2008/
In 2007 24 local MCH coordinated systems contracts with local agencies addressed motor vehicle deaths, unintentional injury and/or suicide.

In 2008 MCH Coordinated Systems contracts with LPHAs will be renewed with 3 MCH health issues addressed. Reducing Intentional and Unintentional Injuries will be focus of some contracts with population-based services and community initiatives addressing injury prevention in MCH population.
//2008//

/2009/
In 2008 are addressing intentional and unintentional injuries in their MCH Coordinated Systems contracts.
//2009//

B.4. INFRASTRUCTURE SERVICES

Infrastructure building services encompass centralized data collection system and surveillance systems and research. Collection, management and dissemination of data on MCH health status, outcomes, process and structure develop effective and accountable delivery system serving MCH populations. Customized data systems track national and state MCH performance measures. MCH health status indicators are integrated in data systems already supported by CHIME partnerships with managed care plans to track and analyze best practice MCH indicators, a crucial element of Missouri's evolving MCH electronic information system.

Also included in coalitions, surveillance systems and networks providing data and research are ECCS Coalition, MCH Information Systems, MICA, PedNSS, PNSS, PRAMS, FAS Surveillance System, Infant Morality and Healthy Birth Outcomes research, MCH epidemiological services, women's health networks and continuous quality improvement teams.

/2007/
BHI continues the partnerships.
//2007//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	92.4	99.2	96.2	98.6
Numerator	73	85	127	101	139
Denominator	73	92	128	105	141
Data Source					DHSS Bureau of Genetics and Healthy Childhood.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
Source: MO DHSS Bureau of Genetics and Healthy Childhood. Fatty Acid disorder infant who had a positive newborn screen for MCAD died from complications to MCAD soon after confirmation.

Notes - 2007
Decreasing percentages since 2005 are partially attributed to the increased number of conditions screened and the complexity of the follow up testing that leads to diagnosis which may require several months for completion.

a. Last Year's Accomplishments
A Web-based electronic birth certificate was being developed which will include newborn hearing and metabolic and other screening of newborns. This will facilitate the ability to see completeness of screening by hospital on a more timely basis. The project is scheduled for implementation on January 1, 2010.

The Newborn Screening Program continued to work with ITSD to improve the current data management and report system to allow reliable statistics based upon all metabolic newborn screen results in the system.

DHSS continued to contract with the four genetic tertiary centers to support infrastructure for a

statewide program of genetic services that includes follow up of babies with abnormal screens.

In addition DHSS continued to contract with the four accredited cystic fibrosis care centers and hemoglobinopathy resource centers to follow-up on babies with an abnormal newborn screen result.

Discussions were conducted with the Newborn Screening Standing Committee and the Missouri Genetic Advisory Committee about adding biotinidase deficiency to the screening panel. The expertise among the membership allowed Missouri to plan successfully for implementing screening for this condition along with making plans for subsequent follow-up and treatment of confirmed cases.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. All infants born in Missouri are screened for 29 of the 29 disorders recommended by the American College of Medical Genetics and the March of Dimes		X	X	
2. Provision by Genetic Tertiary Centers in four university-affiliated medical schools of genetic diagnostic evaluations and counseling, genetic screening and genetic education		X	X	
3. Web sites for Newborn Screening		X	X	X
4. Provision by the four nationally accredited cystic fibrosis care centers in Missouri to provide confirmatory testing for CF, education, counseling and follow-up to assure newborns are receiving appropriate care		X	X	
5. Provision by the three pediatric hemoglobinopathy centers to provide confirmatory testing for conditions detected through the newborn screening program, education, counseling and follow-up to assure newborns are receiving appropriate care. There are		X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Biotinidase deficiency was added to the newborn screening panel on December 31, 2008. With the addition of this, Missouri's newborn screening program is compliant with the 29 core conditions recommended by the American College of Medical Genetics and the March of Dimes. When considering secondary conditions, screening for these disorders allows for a total of 68 disorders to be detected.

Legislation passed in 2007 to expand the income eligibility for those diagnosed with a medical condition requiring a medical formula. The following rules for the expansion became effective on May 30, 2008. The revised financial eligibility guidelines for the Metabolic Formula Program are:

- Birth through five years-of-age: any child is eligible; no financial eligibility guidelines.
- Six through eighteen years of age: there is a pre-pay cost requirement for formula based on the percent of federal poverty level (FPL) calculated from the adjusted gross income and the number of family members.
  1) Below 300% of the FPL, zero cost;
  2) 300% - 399% of the FPL, 25%cost;

3) 400% - 499% of the FPL, 40% cost;
4) 500% and over of the FPL, 50% cost.

- Nineteen years of age and older, 185% of the FPL with an adjustment of two to the family size.

On December 12, 2008, Ornithine transcarbamylase deficiency (OTC) was added as a covered disease to the Metabolic Formula Program as recommended by the Newborn Screening Standing Committee and approved by the DHSS.

c. Plan for the Coming Year

Legislation was passed by the Missouri legislature in 2009 that provides for the screening of five lysosomal storage disorders to be added to the newborn screening panel. The requirement is that screening start by July 1, 2012. The bill does not have the Governor's signature as of this date. To prepare for these disorders, meetings will be held involving the four genetic tertiary centers, the Newborn Screening Laboratory, the Newborn Screening Program (NBSP), and the Newborn Screening Standing Committee. Discussions will include information and materials needed for parents and health care providers, testing methodologies and ranges, what tests are needed to confirm diagnosis, and related topics.

A contract was implemented to develop the web based vital records entry system. This is supposed to be operational by January 2010. The bridge between the Bureau of Vital Records system and the Missouri Health Strategic Architectures & Information Cooperative (MOHSAIC) to match newborn blood spot screens with birth certificates will be developed. Once developed, the NBSP will have the ability to find those babies who have not had a newborn screen prior to hospital discharge. This will facilitate follow-up to achieve a newborn screening when possible.

The Public Health Profile is nearing completion. This is the brief electronic record of children that contains information concerning immunizations, newborn bloodspot screening, newborn hearing screening, special health care needs, child lead, and allergies. It is a tool for a quick review of certain aspects of a child's health that will be available to public and private health care providers. The profile alerts providers if a newborn screening has not been done, if immunizations are not up-to-date, and things of this nature. The profile is being piloted at this time and may be brought online in 2010.

The Newborn Screening Laboratory and the Newborn Screening Program will visit hospitals that have a high percentage of unsatisfactory blood spot forms and provide training to enable the hospitals to take corrective action on newborn blood draws.

The program will continue contracting and partnering with the four genetic tertiary centers and the four accredited cystic fibrosis centers for tracking, follow-up and consultation on abnormal newborn screens. This partnership has been very successful and has resulted in increased communication among those health care providers who provide treatment for these infants and children. Contracts with the adult and pediatric hemoglobinopathy centers will also be continued for follow-up and treatment.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	61.8	64.1	57.2	57.2	64.5

Annual Indicator	57.2	64.1	64.1	64.1	64.1
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	64.7	64.9	65.1	65.3	65.5

Notes - 2008
Indicator data comes from the National Survey of CSHCN conducted by HRSA and CDC, 2005-2006. The next National Survey of CSHCN 2010 data release is fall, 2011.

The 2005-2006 percentage 64.1% in Missouri was close to the 90th percentile state level of 64.2%, and significantly higher than the national figure of 57.4%.

Trend analysis cannot be done until future data becomes available. An annual increase of 0.2% was chosen to create 2009-2013 objectives, based on past performance 2001 and 2005-2006, comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey, and data were comparable across the two time periods

Only two points of data are available, which prevent capacity of performing trend analysis. The 2005-2006 percentage in Missouri (64.1%) was close to the 90th percentile state level of 64.2%. An annual increase of 0.2% was chosen starting from 2006 to create 2008-2012 objectives, based on past performance 2001 and 2005-2006, comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. 2005-2006 data from the National Survey of Children with Special Health Care Needs will be available Fall of 2007.

Updated field note as of May, 2008: The data in 2006 are updated with data from the National Survey of Children with Special Health Care Needs conducted by HRSA and CDC in 2005-2006.

a. Last Year's Accomplishments
SHCN:
--maintained MO Assistive Technology contract to improve access and independence of CSHCN. Participants.
--maintained CSHCN service coordination contracts. CATs, Service Plans and Transition Plans were completed through collaboration with participants. SHCN trained, mentored and provided

technical assistance opportunities for contract staff.
--utilized electronic CAT database for statewide data collection consistent with federal data collection and included components to assess if participants were satisfied with services.
--began Phase 2 of the statewide electronic database enhancement to focus on Financial Management.
--met participant needs; provided culturally competent services and trained contract agency staff to better serve participants. Translated publications enabled non-English speaking people to obtain program and service information. SHCN monitored Missouri demographics to continue addressing translation/interpreter issues and participate in events to increase knowledge of cultural diversity, i.e., planning meeting for American Indian Council Symposium, West Central Multicultural Forum, Ozark Regional Alliance meeting, Annual Ethnic Festival, Vietnamese Community Center, Community Works, Cross Cultural Interpreter training.
--maintained contract with LPHA to administer FP Initiative and build support network for family members providing input on specific special needs issues. FP provided outreach activities encouraging FP participation. SHCN participated in various family focused coalitions.
--continued record review process with programs implemented through SHCN employees.
--recruited health care professionals to assure participant satisfaction. SHCN staff trained in GIS mapping to identify participant and provider needs. Provider Fact Sheet provided participants with information to obtain adequate providers and improve satisfaction.
--promote staff participation in professional development; continued SHCN Training Academy requirements, creating educated, efficient workforce to improve participant services and satisfaction.
--participated in emergency preparedness activities to ensure SHCN populations are considered. SCs contacted participants/families after significant weather events to assure participant safety and disaster planning was successful; provided American Red Cross Disaster Preparedness Booklets to SHCN participants; partnered with participants to complete plans and discussed emergency preparedness with participants/families.
--partnered with Family Voices of Missouri and UMKC to establish a FTF Health Information Center. The goal of the project was to provide information, training, and personal support to families of children and youth with special health care needs.
--partnered with UMKC who received a grant for service integration. The goal of this project is to improve and sustain access to quality, comprehensive, coordinated community based systems of services for children and youth with special health care needs and their families in Missouri.
--partnered with the UMC Thompson Center who received a grant for Improved Services for Children with Autism Spectrum Disorder and other Developmental Disabilities.
--assured the Family Care Notebook was available to families upon request. The FCN categorizes medical information about community-based service systems and assists families in locating appropriate services that best meet their needs.

MOCCRRN assisted 1,136 families with CSHCN in finding and maintaining child care that meets each family's needs and collected data regarding family's satisfaction with services. CCHC provided on-site consultation to support all other child care health consultation efforts, including educating child care providers on care of CSHCN. CCHC and MOCCRRN trained child care providers and parents to accomplish goals of health needs and inclusion services.

In 2008, the School Health Services program in collaboration with the School Boards' Association partnered with Sickle Cell program to develop and disseminate an "Educator's Guide to Children with Sickle Cell Disease" in paper and DVD format. The School Health Services program offered six workshops for school nurses on developing individualized heath care plans and 504 plans for children in need of accommodations in the school setting. The program included management of children with asthma, communication with parents, as well as objective measures for school nurses related to the severity of asthma.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Assistive Technology for CSHCN	X	X		X
2. Comprehensive Assessment Tool (CAT)		X		X
3. Cultural Competency Education and Translated Publications		X		X
4. Family Partnership Initiative (support network for family members)		X		X
5. Provider Recruitment and Provider Fact Sheet		X		X
6. Service Coordination for individuals with special health care needs and Service Coordination Competency		X		X
7. SHCN Staff Training Requirements		X		X
8. Inclusion Specialist and families work together to find appropriate child care for children with SHCN		X		
9. Child Care Health Consultation provided consultation and education to child care providers on the care of children with SHCN		X	X	
10. DVD/CD developed for use by school health professionals and school educators on managing children in the school setting with diabetes, epilepsy or asthma				X

b. Current Activities

SHCN continues to:
-maintain contracts for MO Assistive Technology; cyshcn service coordination; FP Initiative; an additional FP was hired to provide service to SE MO
-integrate assessment data into participant database
-implement Phase 2 (Financial Management) of the statewide electronic database
-provide culturally competent services, training and activities
-translate publications for non English speaking people
-participate in family-focused coalitions
-conduct record review process
-recruit health care professionals; distribute Provider Fact Sheet
-develop/utilize GIS tools
-require staff training
-participate in emergency preparedness activities
-partner with Family Voices of Missouri and UMKC on the FTF Health Information Center Grant
-partner with UMKC on the SIG
-partner with the UMC Thompson Center on Autism Grant
-maintain Family Care Notebook

MOCCRRN assists families with cyshcn in finding and maintaining child care; collect data regarding families' satisfaction. Parent Central is electronic resource to share information with over 70,000 parents. Inclusion Specialists provide technical assistance to child care providers. CCHC provides child care providers on-site consultation/education on care of cyshcn and assists in creation of IHAP and development of policies on care of cyshcn.

School Health Services continues to require IHAP for students with significant SHCN. IHAP serves as a written agreement with student's parent/guardian, health care provider and school personnel.

c. Plan for the Coming Year

MOCCRRN will assist families with CSHCN in finding and maintaining child care that meets each family's needs and to collect data regarding families' satisfaction with services provided. Efforts address state priority needs of supporting early childhood development and education, improving mental health of MCH populations and reducing intentional/unintentional injuries among infants,

children and adolescents.

CCHCs will provide education and consultation to child care providers and parents of children in child care on care of CSHCN and assist child care providers to create individualized health plans for CSHCN and child care policies as indicated.

SHCN will:
--maintain and monitor MO Assistive Technology, CSHCN Service Coordination and Family Partnership Initiative contracts.
--provide culturally competent services and activities described above.
--translate publications to enable non-English speaking people to obtain program and service information.
--participate in family-focused coalitions.
--plan to conduct a satisfaction survey with SHCN participants.
--conduct record review process.
--require staff training to promote professional development and education; revise processes for operational effectiveness and efficiency.
--participate in emergency preparedness activities.
--maintain Family Care Notebook.
--complete integration of assessment data into participant database and continue statewide data collection.
--complete Phase 2 of statewide electronic database enhancement to focus on Financial Management.
--begin development of phase 3 of the electronic database enhancement which includes eligibility and participant management.
--recruit health care professionals and distribute Provider Fact Sheet.
--develop skills and utilize GIS tools.
--partner with Family Voices of Missouri and UMKC on the Family to Family Health Information Center Grant.
--partner with UMKC on the service integration grant.
--partner with the UMC Thompson Center on the State Improvement Grant for Improved Services for Children with Autism Spectrum Disorder and other Developmental Disabilities.

School Health Services has a three year performance measure to increase the percent of children with chronic conditions/special health care needs participating in the development of individualized health care plans to address mutually desired goal(s). Plans are developed by the School Nurse in collaboration with parents and the health care provider, when appropriate. This year, School Nurse regional workshops will focus on culturally sensitive communication and health literacy. The School Health Services program serves nearly 50% of the schools in Missouri.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	58.6	59.6	60.6	61.6	52.2
Annual Indicator	55.7	51.8	51.8	51.8	51.8
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	52.4	52.6	52.8	53	53.2

Notes - 2008
Indicator data comes from the National Survey of CSHCN conducted by HRSA and CDC, 2005-2006. The next National Survey of CSHCN 2010 data release is fall, 2011.

The 2005-2006 percentage 51.8% in Missouri was close to the 75th percentile state level, and significantly higher than the national figure of 47.1%

Trend analysis cannot be done until future data becomes available.
An annual increase of 0.2% was chosen to create 2009-2013 objectives, based on data 2005-2006, comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Trend analysis cannot be conducted until we have future data available. The 2005-2006 percentage in Missouri (51.8%) was close to the 75th percentile state level of 51.6%. An annual increase of 0.2% was chosen starting from 2006 to create 2008-2012 objectives, based on comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. 2005-2006 data from the National Survey of Children with Special Health Care Needs will be available Fall of 2007.

Updated field note as of May 2008: The data in 2005 are updated with data from the National Survey of Children with Special Health Care Needs conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
SHCN:
--completed CAT with SHCN participants. The CAT is a comprehensive view of participant needs and contains criteria to identify whether the participant has a MH, consistent with the MCHB definition of MH. If it was determined the participant did not have a MH, MH educational materials were provided to the family to ensure coordinated, ongoing, comprehensive care for SHCN participants.
--began Phase 2 of the statewide electronic database enhancement to focus on Financial Management.
--utilized electronic CAT database for statewide data collection, consistent with federal data collection, and included components to assess if participants were satisfied with services. SHCN will be integrating CAT data into an all-inclusive participant database.
--continued record review process with programs implemented through SHCN employees that

include MH components.
--partnered with Family Voices of Missouri and UMKC who received a grant to establish a Family to Family Health Information Center. The goal of the project is to provide information, training, and personal support to families of cyshcn.
--partnered with UMKC who received a grant for service integration. The goal of this project is to improve and sustain access to quality, comprehensive, coordinated community based systems of services for cyshcn and their families in Missouri.
--partnered with the UMC Thompson Center in UMC, who received a Autism Grant.
--promoted MH philosophy through education and training opportunities. The MH Fact Sheet was distributed through the SHCN Web site, the Family Care Notebooks and at health fairs/conferences.
--completed Reynolds County Health Center contract that implemented MH initiative. Grant funding through Missouri Foundation for Health (MFH) was used to promote and maintain the MH contract.

Referral network for genetic services continued 4 contracts with genetic tertiary centers.

School Health Services tracked number of: completed referrals for hearing and vision screenings and children with dental provider and dental examination within last 12 months and used School Nurses, Social Workers and SHAC to address barriers to referral completion in local communities. 5,785 878 vision referrals were completed; 1,477 school 1,125 school children received professional follow-ups related to failed hearing screenings; 9,620 9,956 children were referred for dental care.

Oral Health PSP continued to work with communities to implement PSP in early childhood learning centers, Early Head Start and Head Start Programs and schools with a total of 33,840 children receiving PSP preventive care as of April 20, 2008, during the 2008-2009 school year (4,482 Early Head Start and Head Start children).

The Oral Health Program and Health Resources and Services Administration Maternal Child Health Bureau in partnership with the Missouri Head Start State Collaboration Office, the Missouri Head Start Association, Central Missouri Community Action Head Start and the Missouri Primary Care Association presented Infant Oral Care Training focusing on oral health and pregnancy and oral health care for infants.

The Oral Health Program collaborated with the Missouri Primary Care Association, federally qualified health centers, Department of Mental Health, Elks Mobile Dental Program, Missouri Planning Council and other partners to develop and implement a training program available to dental health professionals on how to provide dental care to special health care needs population. The training to the dental health professionals was conducted in April 2009 in a Train the Trainer workshop. Those dental professionals that participated in this training are now able to assist in training other dental professionals across the state in the care of special health care needs population.

In addition, a curriculum is being developed to train Department of Mental Health staff, caregivers, and parents on oral health care hygiene and to participate in how to best help the patient through the process of receiving dental care. This curriculum was provided to the Department of Mental Health staff in March/April for implementation

MOCCRRN assisted 1,136 SHCN families in finding/maintaining child care and medical services. Inclusion Specialists provided training and on-site technical assistance to child care providers on SHCN. CCHC educated child care providers on the management of asthma in the young child and provided education/consultation regarding the care of other CSHCN.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Comprehensive Assessment Tool (CAT) and Record Review		X		X
2. Promotion of Medical Home		X		X
3. Statistical Data				X
4. Genetic services provided diagnostic evaluation and counseling for individuals and families at risk for genetic conditions		X	X	
5. School Health Services worked with schools to increase access to primary and preventive health care for school-age children; CSHCN were identified and referred into a system of care		X	X	X
6. Regional workshops for School Nurses and School Social Workers on access to care, Medicaid eligibility, outreach and enrollment are conducted on an annual basis		X	X	X
7. Elk's Mobile Dental Units provided primary clinical and preventive dental services for CSHCN and other vulnerable children with referral to Truman Medical Center for more comprehensive care	X			
8. 161 Head Start programs have participated during school year 2008-09 in Oral Health PSP involving 4,482 children		X	X	X
9. MOCCRRN assisted SHCN families in finding/maintaining child care and medical services; Inclusion Specialists provided training and on-site technical assistance to child care providers on SHCN		X	X	
10. CCHC educated child care providers/parents on the management of young children with asthma and other SHCN		X	X	

b. Current Activities

SHCN continues to:

--collect assessment information electronically and integrate data into an all-inclusive participant database. In October 2008, SHCN began using the SCA, which replaced the CAT. The SCA uses the MCHB definition of MH to identify participants with a MH.

--provide MH educational materials to families of cyshcn who do not have a MH as determined by the SCA.

--ensure coordinated, ongoing comprehensive care for SHCN participants through SC.

--implement Phase 2 of the statewide electronic database enhancement to focus on Financial Management.

--promote MH through education and training.

--conduct record reviews with programs implemented through SHCN employees that include MH components.

--partner with FVM and UMKC on the grant to establish a FTF Grant.

--partner with UMKC on the SIG.

--partner with the UMC on Autism Grant.

--distribute MH Fact Sheet on SHCN Web site, in FCN and at health fairs/conferences to improve services and promote sustainability of MH system.

MOCCRRN provides technical assistance to families and providers about the importance of establishing and maintaining a MH for children with SHCN. Inclusion Specialists provide training and on-site technical assistance to child care providers on SHCN. In addition, MOCCRRN provides referrals to First Steps and to the CSHCN SC Program. CCHC Program assists families of children in child care with accessing a source of health insurance or primary health care provider as requested.

c. Plan for the Coming Year
MOCCRRN will continue to provide technical assistance to families and providers regarding the importance of establishing and maintaining a MH for children with SHCN. In addition, MOCCRRN will continue to provide referrals to First Steps and to the CSHCN Service Coordination Program. These efforts also address the state priority need of "Improving the Mental Health Status of MCH Populations in Missouri".

CCHCs will continue to facilitate communication between child care providers, parents and healthcare providers regarding CSHCN in child care. CCHC will continue to provide referrals as needed.

SHCN will:
--complete Service Coordination Assessments (SCA) with participants, utilizing MCHB definition of MH to identify participants with a MH.
--provide MH educational materials to families of CSHCN who do not have a MH as determined by the SCA.
--ensure coordinated, ongoing comprehensive care for SHCN participants through service coordination.
--complete integration of assessment data into all-inclusive participant database and continue statewide data collection using Web-based Service Coordination Assessment.
--complete Phase 2 of statewide electronic database enhancement to focus on Financial Management in the electronic database.
--begin development of phase 3 of the electronic database enhancement which includes eligibility and participant management.
--promote MH through education and training by providing MH educational materials to CSHCN populations.
--persist with record reviews of programs that include MH components, implemented by SHCN employees.
--continue distribution of MH Fact Sheet.
--partner with Family Voices of Missouri and UMKC on the grant to establish a Family to Family Health Information Center.
--partner with UMKC on the service integration grant.
--partner with the UMC Thompson Center on the State Improvement Grant for Improved Services for Children with Autism Spectrum Disorder and other Developmental Disabilities.

Missouri School Health Services Program has a three year performance measure to "increase the percent of students whose health record indicates an identified medical provider/clinic". School Nurses and School Social Workers work with students, parents and providers to assure continuity of care. This program reaches approximately 300,000 school age children. This year the program will continue with professional development activities related to health literacy, cultural competency and principals of social marketing.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	67.2	67.8	68.4	69	64.8
Annual Indicator	66	64.8	64.8	64.8	64.8
Numerator					
Denominator					

Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	64.8	65	65	65	65.2

Notes - 2008
Indicator data comes from the National Survey of CSHCN conducted by HRSA and CDC, 2005-2006. The next National Survey of CSHCN 2010 data release is fall, 2011.

The percentage in Missouri in 2005-2006 (64.8%) was at the 65th percentile state level and slightly higher than the national level of 62%. Although there was a slight decrease in the measure from 2001 to 2005-06 in MO, the decrease was not statistically significant.

Trend analysis cannot be done until future data becomes available. With consideration of the economic environment and potential policy changes, it is difficult to make predictions on this measure. 2009-2013 objectives were based on data 2005-2006 and 2001, comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey, and the data were comparable across the two time periods.

Only two points of data are available, which prevent capacity of performing trend analysis. The 2005-06 percentage in Missouri (64.8%) was at the 65th percentile state level. In light of potential changes in policy and other environmental factors, it is difficult to make predictions on this measure. 2008-2012 objectives were chosen, based on comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. 2005-2006 data from the National Survey of Children with Special Health Care Needs will be available Fall of 2007.

Updated field note as of May 2008: The data in 2005 are updated with data from the National Survey of Children with Special Health Care Needs conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
SHCN:
--maintained standard protocols for SCs to monitor the status of MHN referrals and the ability to obtain participants' MHN status through data linkage with DSS.
--continued to participate in various activities, collaborating with other entities to promote adequate insurance for participants.
--distributed the Insurance Comparison Checklist and the Insurance Fact Sheet, which empower families with the necessary resources for obtaining adequate insurance. Both were available on the SHCN Web site, in Family Care Notebooks and at health fairs/conferences.

--trained SCs on how to assist potential participants in determining available resources for adequate insurance.
--collaborated with managed care organizations, SCB, DSS, DMH, and DESE to obtain information about cyshcn that transition within the systems of care.
--completed the CAT with SHCN participants, which included assessing adequacy of insurance.
--utilized electronic CAT database for statewide data collection consistent with federal data collection and compared participant data with data reported through national surveys.
--began Phase 2 of the statewide electronic database enhancement to focus on Financial Management.
--administered CSHCN-Hope Program (RSMo, CCS), which provides early identification and health services that includes service coordination, diagnostic and treatment services involving medical care, hospitalization and aftercare to participants who require sub-specialty, specialty, preventive and primary care. Medicaid referral and enrollment, or verification of active enrollment, was required of all participants. ACM was continued through a cooperative agreement SHCN maintained with DSS MHN. SHCN authorized the medical necessity of in-home nursing services and provided service coordination for participants.
--partnered with Family Voices of Missouri and UMKC who received a grant to establish a Family to Family Health Information Center. The goal of the project is to provide information, training, and personal support to families of cyshcn.
--partnered with UMKC who received a grant for service integration. The goal of this project is to improve and sustain access to quality, comprehensive, coordinated community based systems of services for cyshcn and their families in Missouri.
--partnered with the UMC Thompson Center who received a Autism Grant.

Baby Your Baby Web site (www.dhss.mo.gov/babyyourbaby) provided information for pregnant women, their families and communities on healthy pregnancies and healthy babies. The site includes a wide range of topics including MC+ and financial resources for pregnant women and children. This Web site will remain active through January 2013.

All School Health Services Program school contracts have a performance measure to increase number and percent of school-age children with a medical home; track children without health insurance; assist families with MHN applications. School Nurses and School Social Workers in the School Health Services Program received an annual update in regional settings on MHN enrollment procedures. Barriers to enrollment including cultural competency and health literacy strategies were addressed in regional settings. MCH Coordinated Systems contracts strengthened LPHAs' efforts to target children without insurance and assisted their families in obtaining public/private health care coverage.

MOCCRRN provides all families calling for child care referrals with MHN information. CCHC program assisted with referrals/assistance with accessing MHN as requested.

DCPH/ITSD provided integration of multiple single purpose databases into single system to support child-centered record including MHN status.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaboration with other entities to promote adequate insurance for participants		X		X
2. Exchange of information conducted with MCOs, DSS, DMH and DESE for children transitioning within systems of care		X		X
3. Comprehensive Assessment Tool (CAT) assesses adequacy of insurance		X		X
4. CSHCN Hope Program provided early identification and health	X	X		

services				
5. Baby Your Baby Web site provided info for pregnant women, their families and communities including info on MC+ and financial resources			X	X
6. MCH Coordinated Systems contracts with LPHAs developed community specific interventions to target risk factors such children without health insurance and incorporated early identification and referrals to MC+ into direct services	X	X	X	X
7. CCHC program referred/connected children in child care with a source of health care coverage		X		
8. MOCCRRN provided resource information to each caller including information regarding access to health insurance and/or Medicaid		X		
9. DCPH/ITSD's child-centered record included Medicaid status			X	X
10.				

b. Current Activities
SHCN continues to:
--maintain protocols to monitor the status of MHN referrals.
--maintain DSS data linkage.
--collaborate and distribute materials to promote adequate insurance.
--train to determine available adequate insurance resources.
--determine adequacy of participant's insurance by completing assessments.
--complete integration of assessment data into participant database.
--utilize statewide electronic SCA database.
--implement Phase 2 of the statewide database to focus on Financial Management.
--administer the CSHCN Program and cooperative agreement with DSS-MHD for ACM.
--partner with FVM and UMKC on the FTF Grant.
--partner with UMKC on the SIG.
--partner with UMC on the Autism Grant.

School Health Services tracks number and percent of children in School Health Services Program with regular source of medical care and provide outreach to families with no or inadequate health insurance. Regional meetings conducted with School Nurses/Social Workers to provide information regarding community-based systems such as FQHCs as well as tips to assist families enrolling in MHN.

MOCCRRN provides all families calling for child care referrals with MHN information. CCHC assists families of children in child care with accessing a source of health insurance or primary health care provider as requested.

DCPH/ITSD continued to provide integration of multiple single purpose databases into a single system that supports a child-centered record including MHN status.

c. Plan for the Coming Year
MOCCRRN will continue to provide all families calling for child care referrals with MHN information. These efforts also address state priority need of "Improving the Mental Health Status of MCH Populations in Missouri".
CCHCs will continue to provide information to child care providers and parents regarding MHN as well as local programs of assistance for CSHCN.

SHCN will:
--maintain protocols and evaluate methods (modifying if necessary) to improve SHCN procedure for SCs to monitor participants on their MO HealthNet status; continue to enable SC's ability to

attain the participants' MO HealthNet status through data linkage with DSS.
--collaborate with other entities to promote adequate insurance for participants.
--distribute Insurance Comparison Checklist and Insurance Fact Sheet to empower families with resources to obtain adequate insurance.
--persist with SC training on how to determine available resources for adequate insurance.
--collaborate with entities to obtain information about CSHCN transitioning within systems of care.
--collaborate with Department of Insurance, Financial Institutions and Professional Registration.
--assess if a participant has adequate insurance by completing the Service Coordination Assessment with SHCN participants.
--complete integration of assessment data into all-inclusive participant database and continue statewide data collection using Web-based Service Coordination Assessment.
--complete Phase 2 of statewide electronic database enhancement to focus on Financial Management.
--begin development of phase 3 of the electronic database enhancement which includes eligibility and participant management.
--administer CSHCN Program.
-- continue cooperative agreement with DSS-MHD for ACM through the HCY Program.
--partner with Family Voices of Missouri and UMKC on the grant to establish a Family to Family Health Information Center.
--partner with UMKC on the service integration grant.
--partner with the UMC Thompson Center on the State Improvement Grant for Improved Services for Children with Autism Spectrum Disorder and other Developmental Disabilities.

School Health Services Program has performance measure to increase percent of children with regular source of medical care. This year the program will again sponsor regional meetings with School Nurses and School Social Workers on MHN enrollment procedures for families, eligibility guidelines and suggestions to frequently identified barriers. Additionally the FQHC system will be highlighted. The MHN Outreach Speaker will provide in-depth orientation for new School Nurses. A Back-to-School E-Newsletter will be sent to all School Nurses in August (approximately 1,300) regarding MHN. Outreach information for parents and posters for School Nurses' Offices will be offered.

DCPH/ITSD will continue to provide integration of multiple single purpose databases into a single system that supports a child-centered record including Medicaid status.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	78.4	80	81.6	83.2	90.5
Annual Indicator	75.2	90.1	90.1	90.1	90.1
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90.7	90.9	91.1	91.3	91.5

Notes - 2008
Indicator data comes from the National Survey of CSHCN conducted by HRSA and CDC, 2005-2006. The next National Survey of CSHCN 2010 data release is fall 2011.

The percentage in Missouri in 2005-2006 (90.1%) was close to the 75th percentile state level, and slightly higher than the national level of 89.1%.

Trend analysis cannot be done until future data becomes available. An annual increase of 0.2% was chosen to create 2009-2013 objectives, based on data 2005-2006, comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Trend analysis cannot be conducted until we have future data available. The 2005-06 percentage in Missouri (90.1%) was close to the 75th percentile state level of 90.8%. An annual increase of 0.2% was chosen starting from 2006 to create 2008-2012 objectives, based on comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. 2005-2006 data from the National Survey of Children with Special Health Care Needs will be available Fall of 2007.

Updated field note as of May 2008: The data in 2005 are updated with data from the National Survey of Children with Special Health Care Needs conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
SHCN:
--utilized database for statewide assessment data consistent with federal data collection and included components to assess if providers were accessible and services filled participant needs at community level.
----maintained MO Assistive Technology contract (monitored for quality) to improve access and independence of CSHCN; encouraged community-based partnership among assistance technology services, participants and SHCN.
--participated in outreach activities with external agencies to promote organized community-based service systems for CSHCN.
--maintained CSHCN Service Coordination contracts (monitored for quality) and conducted outreach and promotional activities to increase public knowledge of SHCN services. CATs, Service Plans and Transition Plans were completed with participants. SHCN trained, mentored and provided technical assistance opportunities for contract agency staff.
--provided culturally competent services and trained contract agency staff to better serve participants. Translated publications enabled non-English speaking people to obtain program and service information. Monitored state demographics to continue addressing translation/interpreter issues and participated in events to increase knowledge of cultural diversity.
--maintained LPHA contract (monitored for quality) to administer FP Initiative and build support

network for family members providing input on specific special needs issues. FP provided outreach activities encouraging FP participation resulting in increased participation. SHCN participated in family-focused coalitions.
--partnered with FVM and UMKC who received a grant to establish a FTF Health Information Center. The goal of the project is to provide information, training, and personal support to families of children and youth with special health care needs.
--partnered with UMKC who received a SIG. The goal of this project is to improve and sustain access to quality, comprehensive, coordinated community based systems of services for cyshcn and their families in Missouri.
--partnered with the UMC Thompson Center who received an Autism Grant.
--recruited health care professionals to assure adequate medical care for participants to receive community-based services. SHCN staff trained in GIS mapping to identify participant and provider needs.
--participated in statewide promotional activities increasing knowledge, understanding and availability of all programs and services for SHCN individuals resulting in more Missourians receiving service.
--promoted staff participation in professional development by utilizing presentations about SHCN programs and services; continued SHCN Training Academy requirements, creating educated, efficient workforce with emphasis on community needs and outreach activities.
--participated in emergency preparedness activities to ensure SHCN populations were considered. Contacted participants/families after significant weather events to assure participant safety and disaster planning was successful; provided ARC Disaster Preparedness Booklets to participants; partnered with participants to complete plans and discuss emergency preparedness with participants/families.
--maintained the Family Care Notebook and included feedback from participants/families. Statewide electronic version was maintained and distributed as requested. Notebook categorizes medical information about community-based service systems and assists families in locating appropriate services to best meet their needs.

School Health Services collaborated with LPHAs, mental health community-based agencies, local education agencies and other child serving agencies on confidentiality barriers. A workshop on Health Literacy was offered in regional settings for school health professionals addressing, "Why Parents Cannot Hear What You are Saying and Strategies for Working with Parents".

MOCCRRN distributed child care resources and referral services information for CSHCN at 156 local community events; provided access to training for child care providers through electronic training calendar; provided technical assistance for parents/providers regarding SHCN; made referrals to First Steps, Thompson Center for Autism and Neurodevelopmental Disorders and other area resources. SCCR prioritized 2008 standardized hands-on training for child care providers with supporting material. CCHC provided families with assistance accessing a source of health care coverage or a health care provider as needed.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Comprehensive Assessment Tool (CAT)		X		X
2. Assistive Technology for CSHCN	X	X		X
3. Cultural Competency Education and Translated Publications		X		X
4. Family Partnership Initiative (support network for family members)		X		X
5. Provider Recruitment		X		X
6. SHCN staff participated in outreach activities assuring collaboration with external agencies and promoting organized		X		X

community-based service systems for CSHCN				
7. MCH staff sit on the Bright Futures State Planning Committee, a community development initiative to promote mental health in children and families by using a public health model		X	X	X
8. MOCCRRN distributes information regarding child care referral services at local community events and through physician's offices		X	X	
9. MCH Coordinated System's outcome-based contracts are focused on systems development and effective community collaboration			X	
10.				

b. Current Activities

SHCN continues to:
-collect data electronically for statewide assessment. SHCN began using the SCA, replacing CAT and integrating data into all-inclusive database.
-maintain contracts for AT, CSHCN Service Coordination, and FP. An additional FP was added to serve the SE region.
-partner with FVM and UMKC on the FTF Grant.
-partner with UMKC on the SIG.
-partner with the UMC on the Autism Grant.
-provide culturally competent services.
-recruit health care professionals.
-develop/utilize GIS tools.
-participate in promotional activities.
-promote professional development.
-participate in emergency preparedness activities.
- maintain FCN.

SHCN and OHP with DMH, SSSH and Sheltered Workshops are developing local oral healthcare services systems for vulnerable populations.

School Health Services continues to offer consultations and workshops for School Nurses and school staff on community and Web-based resources.

MOCCRRN promotes inclusion services at local community events and physician offices and provides referrals to community services statewide in response to phone or electronic inquiries from families. Inclusion Specialists provide training to child care providers regarding the needs of families through the delivery of "Building Partnerships with Parents and Families", which is Module IV of Child Care plus, Missouri's standardized inclusion-related curriculum. CCHC program provides consultation/education to child care providers on the care of CSHCN.

c. Plan for the Coming Year

MOCCRRN will promote services at local community events; provide referrals to community services in phone calls with families; provide training to child care providers on needs of families through delivery of "Building Partnerships with Parents and Families". Efforts address state priority needs of adequate early childhood development and education, mental health status of MCH populations and reducing intentional and unintentional injuries among infants, children and adolescents.

CCHCs will continue to facilitate communication between child care providers, families and community-based services for CSHCN.

SHCN will:
--complete integration of assessment data into all-inclusive participant database and continue statewide data collection.
--maintain and monitor MO Assistive Technology contract; LPHA contracts to provide CSHCN service coordination; LPHA contract to administer Family Partnership Initiative.
--participate in outreach activities to promote organized community-based service systems for CSHCN.
--provide culturally competent services; translate publications to meet the needs of non-English speaking people; and participate in events to increase knowledge of cultural diversity
--recruit health care professionals.
-- develop/utilize GIS mapping tools.
--promote activities statewide to incite referrals for more CSHCN to receive services.
--promote staff professional development.
--participate in emergency preparedness activities and distribute emergency preparedness materials.
--maintain Family Care Notebook.
--begin development of phase 3 of the electronic database enhancement which includes eligibility and participant management.
--partner with FVM and UMKC on the FTF Grant.
--partner with UMKC on the SIG.
--partner with the UMC Thompson Center on the Autism Grant.

SHCN and OHP with DMH, SSSH and Sheltered Workshops are developing local oral health care services systems for vulnerable populations.

This year, the Missouri School Health Services Program will work to infuse Health Literacy and Cultural Competency concepts into the practices of School Nurses and School Social Workers so that they can be better advocates for the families they serve. The School Health Program has a performance measure to improve on an annual basis the referral completions for health related issues. This year, the program will explore reasons for parents not following through on referrals from school.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	9.4	6	6.5	7	54.4
Annual Indicator	5.8	54.4	54.4	54.4	54.4
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	54.4	54.6	54.6	54.6	54.8

Notes - 2008
Indicator data comes from the National Survey of CSHCN conducted by HRSA and CDC, 2005-2006. The next National Survey of CSHCN 2010 data release is fall 2011.

Missouri had the highest percentage of receiving services for transition to adulthood among all states in 2005-2006 (54.4%, MO vs. 41.2%, US).

Trend analysis cannot be done until future data becomes available. 2009-2013 objectives were chosen, based on data 2005-2006, comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Trend analysis cannot be conducted until we have future data available. Missouri had the highest percentage in this measure among all states in 2005-2006. 2008-2012 objectives were chosen, based on comparisons to other states, and discussions with the Bureau of Special Health Care Needs, MO DHSS.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. 2005-2006 data from the National Survey of Children with Special Health Care Needs will be available Fall of 2007.

Updated field note as of May 2008: The data in 2005 are updated with data from the National Survey of Children with Special Health Care Needs conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
SHCN:
--utilized electronic CAT database for statewide data collection consistent with federal data collection and included components to assess if youth with SHCN received necessary services and supports for transitions.
--collaborated with programs and services that served adults to assist youth in transitioning smoothly to appropriate adult services.
--partnered with FVM and UMKC who received a grant to establish a FTF Health Information Center. The goal of the project is to provide information, training, and personal support to families of cyshcn.
--partnered with UMKC who received a SIG. The goal of this project is to improve and sustain access to quality, comprehensive, coordinated community based systems of services for cyshcn and their families in Missouri.
--partnered with the Thompson Center in UMC who received a Autism Grant.

SCs assisted with participants and collaborated with key agencies to plan for transitions, utilizing several planning tools. SHCN staff provided training to SCs and identified participants who have upcoming life stage transitions. SHCN reviewed transitional materials to determine if additional resources were necessary to improve transition planning.

The School Health Services Program continued to offer training programs for School Nurses to address students with special healthy care needs and IHAPs. The Individualized Health Care Plans are developed in partnership with parents and when appropriate other health care professionals.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Comprehensive Assessment Tool (CAT)		X		X
2. Transition Plans		X		X
3. Collaboration with adult programs and services		X		X
4. School Health Services Program continued to offer training programs for School Nurses to address students with SHCN	X		X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

SHCN continues to:

--collect assessment information electronically including components to assess if cyshcn receive necessary services and supports for transitions.

--assist participants and collaborate with agencies to plan for transitions. SHCN utilizes several planning tools, provides training and identifies participants who have an upcoming life stage transition. SHCN reviews transitional materials to determine if additional resources are necessary to improve transition planning.

--collaborate with adult services to assist and plan for participants' smooth transitions to appropriate adult services, work with programs and agencies that serve adults to assist in planning for youth transitions; review and revise processes to assure effective youth transition planning.

--partner with FVM and UMKC on the FTF Health Information Center Grant.

--partner with UMKC on the SIG.

--partner with the UMC Thompson Center on the Autism Grant.

--integrate assessment data into all-inclusive participant database and continues statewide data collection using Web-based SCA.

ADOLESCENT SHORTS issues are focusing on transitioning cyshcn to adult health care services and showcasing related DHSS services.

c. Plan for the Coming Year

SHCN will:

--continue collection of Service Coordination Assessment data that will include components to assess if youth with SHCN receive the necessary transition services and support. Data analysis will continue to focus on regional needs and continue to be an efficient tool for caseload management. SHCN will complete the integration of CAT data into an all-inclusive participant database and continue statewide data collection using a Web-based Service Coordination Assessment.

--work with participants and agencies to plan for transitions. SHCN will continue to use several planning tools, provide training and identify participants who have an impending life stage

transition. SHCN will persist in the review of transitional materials to ascertain if additional resources are necessary to improve transition planning. SHCN will continue to explore ways to measure satisfaction of transitions to include SHCN participants of all ages.
--collaborate with adult services to assist/plan for smooth participant transitions into appropriate adult services, work with programs and agencies that serve adults to assist in planning for youth transitions; and continue to review and revise processes assuring effective youth transition planning.
--collaborate with UMKC on the State Implementation Grants for CYSHCN to implement a statewide plan of integrated services at individual, community and state levels. The collaborative goal is to improve and sustain access to quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families in Missouri. The plan for the upcoming year also includes establishing a Youth Advisory Council comprised of youth with special health care needs.
--collaborate with UMKC on the Family-to-Family Health Information and Education Center to build significant partnerships between consumers, families and professionals, which include addressing the needs of families from diverse racial, ethnic and cultural backgrounds. The collaborative goal is to provide information, training and personal support to families of CYSHCN and professionals through collaborative partnerships that create improved access to healthcare, positive health outcomes, successful transitions and an improved quality of life.

The School Health Services Program will continue with professional development sessions for School Nurses on the role of the School Nurse on the Individualized Education Plan (IEP) team.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	77.1	81.6	85.2	82.3	82.9
Annual Indicator	83.3	79.3	79.7	82.1	74.0
Numerator	62614	61029	61934	64487	60201
Denominator	75167	76960	77709	78547	81353
Data Source					National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	80.4	81	81.7	82.3	82.9

Notes - 2008
Source: Data is the 4:3:1:3:3 Series (4 DTP, 3 Polio, 1 MMR, 3 Hib, 3 HepB)
CDC National Immunization Survey, Q3/2007-Q2/2008. July 2007-June 2008. Population of infants < 1 year of age in 2006 as denominator estimate of 19-35 months old in 2008.

The immunization rate among children in Missouri had been gradually rising from 72.1% in 1999 to 82.1% in 2007, and comparable with the national figure. The percentage in Missouri in 2008 was lower than that in 2007 and the national estimate in 2008, though the difference was not statistically significant.

MO encountered shortages and delays in Hib vaccine in 2008, which is expected to be resolved in 2009. Some private providers have either discontinued participation in the Vaccines for Children Program or stopped carrying vaccines altogether.

Considering the overall increasing trend in the past 10 years and possible data fluctuation, it is too early to tell the drop in 2008 is a start of decline. Objectives 2009-2013 were based on a combination of trend analyses on data 1999-2008 and discussions with the DHSS Immunization Program.

Notes - 2007
Data is for the 4:3:1:3:3 Series, US, National Immunization Survey, Q3/2006-Q2/2007. Population of infants <1 year of age in 2005 used as denominator estimate of 19-35 month olds in 2007.

2008-2012 objectives are based on trend analysis on data 1998-2007, and discussions with the immunization program, MO DHSS.

Notes - 2006
Data is for the 4:3:1:3:3 Series, US, National Immunization Survey, Q3/2005-Q2/2006. 2007-2011 annual performance objectives based on a logistic regression of 1999-2006 indicators. Population of infants <1 year of age in 2004 used as denominator estimate of 19-35 month olds in 2006.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

a. Last Year's Accomplishments
Missouri was unable to attain the 2008 objective due to a shortage of Hib vaccine and a reduction in the number of health care providers participating in the Vaccines for Children program resulting in referrals to the county health departments for vaccine administration. The Immunization Program is looking into this issue and recently acquired a CDC assignee with specific duties to improve Missouri's rates.

TEL-LINK, DHSS's toll-free information and referral line for maternal, child and family health services, continued to provide a wide variety of referrals including immunization and well child checkups. The toll-free number was promoted through participation at various conferences (Missouri League for Nursing, Missouri State Teachers Association, Missouri National Education Association, Missouri Public Health, Health Summit-Prevention Violence Against Women, and Practical Parenting Partnerships) and health fairs (Missouri Black Expo, Minority Health Awareness and Fulton State Hospital). A variety of health-related literature was distributed to the public and professional organizations. Collaboration efforts were made with other state programs such as WIC, breastfeeding, prenatal birth defects. In addition, TEL-LINK collaborated with the Missouri's Think Before You Drink Campaign" which encouraged women to call TEL-LINK for free educational materials on women's health and alcohol. The campaign was promoted through Facebook, an Internet social network. Advertising of the toll-free number was also accomplished through parenting magazines and newspapers in Springfield, Kansas City and St. Louis. The Hispanic population was targeted in the Kansas City area by referrals for immunizations and advertising TEL-¬LINK in the bilingual newspapers known as DOS MUNDOS and the Kansas City Hispanic News. Additional advertising of TEL-LINK continued in the St. Louis area through postings of kingsize busboards throughout the city and interior cards on the MetroLink.

The Home Visiting and Alternatives to Abortion programs continued to educate mothers on the

need for immunizations and help mothers to obtain a medical home for their infants. Home Visiting programs collected data on immunization compliance for the targeted child for the families enrolled in the programs.

Baby Your Baby Web site (www.dhss.mo.gov/babyyourbaby) provided information for pregnant women, their families and communities on healthy pregnancies and healthy babies. The site includes a wide range of topics including prenatal care, immunizations, well child checkups and special health care needs. This Web site will remain active through January 2013.

Immunization Registry, an electronic registry database designed to hold immunization records for Missouri children, was maintained.

MOCCRRN provided families with information regarding immunizations when families requested child care referrals through phone or electronic inquiries. Immunization schedules as well as explanation of the requirement of up-to-date immunizations for enrollment in child care programs were provided. The CCHC Program provided 80 hours of on-site consultation/technical assistance at child care facilities, 550 phone consultations and 23 hours of group training to child care providers on the topic of keeping immunization records current and the completion of mandatory immunization reports.

MCH Coordinated Systems contracts were revised with three focus areas of injury, obesity and tobacco prevention in the MCH population. Each contractor has a contractual obligation to utilize evidence-based interventions. Local system development includes community-based interventions and environmental and policy change to impact these issues. Contractors may also use contract funds to address immunizations. MCH Coordinated Systems staff support LPHA efforts to assure appropriate immunizations for children through technical and consultative services as needed.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Child Care Health Consultants (CCHCs) provided technical assistance and consultation on immunizations for children enrolled in child care		X		
2. MOCCRN promoted up-to-date immunizations to families calling for child care referrals				X
3. LPHAs developed community specific interventions to target up to date immunizations for two-year olds and increase the number of children entered into the state immunization registry		X	X	X
4. Home visiting and Alternatives to Abortion programs educated mother/families on the need for immunizations and immunization schedules		X	X	
5. Baby Your Baby Web site provided information for a wide range of topics including immunizations and well child checkups			X	X
6. TEL-LINK DHSS's toll-free telephone line provided information and referrals concerning health services including immunizations and well child checkups			X	X
7. MCH Coordinated Systems staff supported LPHA efforts to assure appropriate immunizations for infants and children through technical and consultative services as needed		X	X	X
8.				
9.				
10.				

b. Current Activities
TEL-LINK will continue to provide prenatal referrals and literature on various topics to Missouri women.

Home Visiting programs and Alternatives to Abortion continue presenting immunization information to their clients. Home Visiting program collects data on every child enrolled in the program and their immunization status.

Baby Your Baby Web site continues to provide information for pregnant women, their families and communities on healthy pregnancies and healthy babies and will remain active through January 2013.

Immunization Registry holds immunization records for Missouri children.

MOCCRRN provides families with information regarding immunizations and explains immunizations need to be up-to-date prior to enrollment in child care. CCHCs provide consultation/technical assistance to child care providers on maintenance/monitoring immunization records and preparation of annual immunization status report to DHSS.

MCH Coordinated Systems 3-year contracts with LPHAs focus on the areas of unintentional and intentional injury, obesity and tobacco prevention in MCH population. Each has community-based interventions and environmental and policy changes to impact these issues. Some contractors are also using funding to address immunizations.

c. Plan for the Coming Year
TEL-LINK will provide information and referrals to Missourians concerning immunizations and a wide range of other health services.

MOCCRRN will provide families with information regarding immunizations as they call for child care referrals and to explain to parents that immunizations need to be up-to-date prior to enrollment in a child care program.

CCHCs will provide education and consultation to child care providers/parents regarding maintaining up-to-date immunizations and records for children in child care' facilitate children receiving appropriate, timely immunizations; and assist child care providers in submitting required reporting for immunizations.

MCH coordinated systems staff will continue to support LPHA efforts to assure appropriate immunizations for children through technical and consultative services as needed. The focus of support will be on local system development and educational resources on best practice methods through local, regional and statewide training opportunities and shared resources.

Contractors in the Alternatives to Abortion program will continue to be encouraged to educate mothers enrolled in the program on the need for immunizations and immunization schedules. Information will be provided to the contractors on educational materials they can use to accomplish this.

The Baby Your Baby Web site (www.dhss.mo.gov/babyyourbaby) will continue to provide information for pregnant women, their families and communities on healthy pregnancies and healthy babies. The site includes a wide range of topics including prenatal care, immunizations, well child checkups and special health care needs. This Web site will remain active through January 2013.

The Building Blocks and Missouri Community-Based Home Visiting programs will continue to

educate mothers on immunization schedules of infants and children and utilize the Baby Your Baby information for mothers. Status of immunizations for each individual infant will be tracked in the data system and the program will be evaluated on the effectiveness of the home visitors on educating parents and the completion of immunization schedules.

Immunization Registry will be further developed as a Web-based system for electronic submission of immunization data.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	19.1	19.6	18.4	17.2	21.4
Annual Indicator	21.9	20.8	22.6	21.4	21.2
Numerator	2623	2555	2828	2685	2654
Denominator	119611	123065	124936	125231	125231
Data Source					MO DHSS. Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	21	20.8	20.6	20.4	20.2

Notes - 2008
Source: Missouri Information for Community Assessment (MICA)-Births,
DHSS Vital Statistics, MICA-Population. Numerator is provisional 2008 birth number to women age 15-17 years as April 2009. Final data will be available October 2009. Denominator is 2007 population number being used as proxy for 2008. Final population data will be available November 2009.

The increase in teen birth rate observed in both Missouri and the U.S. in 2006 did not continue in Missouri. Missouri had seen decline for two consecutive years 2007 and 2008 since 2006, and the decrease was across white, African-American, and Hispanic groups. The 2008 provisional teen birth rate in MO was highest in Hispanics (49.4 per 1,000), followed by African-Americans (41.4 per 1,000) and whites (17.2 per 1,000). An annual decrease of 0.2 per 1,000 was chosen to create 2009-2013 targets, based on data in the past two years, and discussions with the DHSS Section of Healthy Families and Youth.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) Birth, MICA Population, and Bureau of Health Informatics, MO DHSS. 2007provisional data as of April 28, 2008. 2007 final data of birth file will be available in October, 2008. 2007 denominator of population estimate for females 15-17 years of age is not available yet, and 2006 population estimate is used as a proxy for 2007. 2007 population estimate will be available in November, 2008.

An annual decrease of 0.2 per 1,000 was set to create future objectives 2008-2012, with considerations of trend analyses on past performance 1998-2007, as well as the fact the teem birth rate rose in 2006 for the first time in the past 15 years in both Missouri and the nation.

Notes - 2006
Data source is Missouri Information for Community Assessment (MICA).
2006 provisional numbers used for denominator as of July 2, 2007.

Annual performance objectives for 2007-2017 based on reasonable estimate of future indicators based on past performance.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

a. Last Year's Accomplishments
AHP continued to provide consultation and education; and promote community, school and health care best practices to promote adolescent health. CASH advised DHSS on priorities for adolescent health and initiatives including continuance of adolescent medicine consultation contract and professional newsletter. ADOLESCENT SHORTS addressed current adolescent health care issues including: HIV and the new CDC guidelines; social networking safety; disordered eating; and alcohol energy drinks.

AHP, Adolescent Medical Consultant contractor, Mo Chapter of the AAP, and other local co-sponsoring organizations conducted 7 trainings on current adolescent health care issues and trends; 695 health and youth-serving professionals trained.

DHSS was a co-sponsor of Region VII Annual HIV/AIDS/STDs & Human Sexuality Education Conference.

DHSS AHP, CASH, and HIV/STD and Hepatitis Programs collaborated to develop comprehensive, statewide community, school, and peer-based HIV, STD, and teen pregnancy prevention strategies.

Missouri's State-Local Team was one of five in the nation selected by the AMCHP and NACCHO for the Evidence-Based Approaches for the Prevention of Teen Pregnancy, STIs, and HIV technical assistance grant. The DHSS, Mississippi County Health Department, local, state, and national partners are collaborating on the development of effective community-based strategies to reduce teen pregnancy and STDs.

TOP was implemented through 3 LPHAs (Phelps, Washington, Columbia/Boone). Wyman, provided training and technical assistance. TOP is a comprehensive youth development approach that has proven effective in increasing school success and protecting youth from risk factors that contribute to teen pregnancy and other negative behaviors. TOP was also offered as an option for abstinence education contractors to implement as strategy to strengthen abstinence education programs for young adolescents.

DHSS programs and partners collaborated with public and professional education on adolescent reproductive health issues (pregnancy prevention, STDs, HPV vaccine and sexual assault).

MCH Coordinated Systems used Title V funds to support community-based interventions through LPHAs to reduce rate of births to teens using best practices, model programs or evidence-based interventions; 32 contractors addressed this issue.

Title V State Abstinence Education Grant Program served 7,110 adolescents and their families.

The MCBHV program in St. Louis County targets pregnant teens through age 2 of their index

child. Enrollees are educated on the need of birth spacing and prevention of unplanned pregnancies. Other MCBHV and Building Blocks programs also include services to teens along with other pregnant women.

Implementation of Building Blocks of Missouri Program continued. Building Blocks of Missouri was reported by Healthy Teen Network and Brookings Institute as a best practice and cost effective measure in decreasing teen pregnancy.

School Health Services Program continues to fund school nursing and school social work positions in small, rural school districts with no identified health services. These programs are advised by SHACs comprised of local community members, parents and educators. More than 700 SHAC meetings were held statewide. The community then addresses sensitive issues such as teen parenting and risky youth behaviors.

School Health Services co-sponsored statewide conferences with a focus on youth and health promotion such as; the Coordinated School Health Conference, School Social Worker Conference, School Nurse Conference and School Boards' Association Conference and provided scholarships for school personnel targeting youth at risk.

State School Nurse Consultant continued to foster collaborative relationships with local school districts and STD/HIV investigators by hosting regional meetings for school staff and STD/HIV investigators.

TEL-LINK provided information/referrals to females concerning family planning, prenatal care and prenatal drug abuse and collaboration of state programs (e.g., breastfeeding, WIC, prenatal birth defects) to educate females about these topics. (The TEL-LINK Web site provides access/link to other statewide health services. Advertising continued through exhibits at conferences and health fairs, posters, parenting/health magazines and news releases.

BHI provided teen births from the vital statistics system, and the number of female teens aged 15 to 17 from population estimates to produce the data for this measure.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Adolescent medicine and health consultation services contract supported the services of a Board-Certified Adolescent Medicine Consultant, training and technical assistance to adolescent health providers, newsletter and ADOLESCENT SHORTS		X	X	
2. Building Blocks of Missouri Program		X		
3. DHSS and DESE joined public health and education agencies for Kansas, Iowa and Nebraska in co-sponsoring regional "Teaching About HIV/AIDS/STDs and Human Sexuality Education" conference		X	X	
4. Teen Outreach Program (TOP) continued with LPHAs and community partners		X		
5. MCH Coordinated Systems offer consultation and technical assistance to LPHAs and school nurses as needed to improve local systems ability to address teen pregnancy through evidence-based best practices			X	
6. TEL-LINK provided information and referrals concerning health services such as family planning, prenatal care, prenatal drug abuse			X	X
7. BHI provided from the vital statistics system teen births, and				X

from population estimates, the number of female teens aged 15 to 17 needed to produce the data for this measure				
8.				
9.				
10.				

b. Current Activities
4 LPHAs implement TOP with school/community partners; Wyman provides training.

Contractors proved abstinence education for adolescents and parent communication strategies.

Children's Mercy Hospital contract is for training, consultation and newsletter.

DHSS co-sponsors trainings on adolescent health with local/state health care, school, and parent organizations; includes Region VII HIV/AIDS/STDs & Human Sexuality Education Conference.

CASH, HIV/STD and Teen Pregnancy Education Youth Committee promote best practices, and Take Control. Take the Test campaign for STDs/HIV awareness and screening.

Adolescent Health Team and CASH increased capacity to address these issues across DHSS.

AMCHP and NAACHO grant supported State-Local Team evidence-based approaches on teen pregnancy and HIV/STI project through December 2008. Contract with Mississippi County Health Department to develop model.

Missouri is one of four states to receive Reconvene Grant to strengthen state public health and education collaboration to address HIV/AIDS, STDs, and teen pregnancy.

Building Blocks and MCBHV educate women on birth spacing to decrease recurrent teen pregnancies.

Statewide media campaign, Talk with me, launched to encourage parents to talk with their kids about sex, values, and healthy decisions. Information available at www.dhss.mo.gov/AdolescentHealth

TEL-LINK provided referrals on family planning. Ads were placed in DOS MUNDOS and the KANSAS CITY HISPANIC NEWS(bilingual newspapers in Kansas City).

c. Plan for the Coming Year
TEL-LINK will provide information and referrals as described above plus interior bus cards, targeting minorities in Metro areas.

DHSS will contract with LPHAs to implement TOP and with Wyman in St. Louis to provide training and technical assistance.

Missouri is 1 of 5 states developing state/county collaborative project for "Evidence-Based Approaches to Teen Pregnancy and HIV/STI Prevention". DHSS programs will collaborate with Mississippi County public health, school, and community.

DHSS programs will also provide technical assistance to LPHAs and community partners interested in developing local coalitions and strategies.

Missouri is 1 of 4 states selected for the Reconvene Initiative to strengthen state public health

and education collaborative efforts to address HIV/AIDS, STDs, and teen pregnancy. Missouri's plan includes identifying and serving youth in non-traditional educational settings, promoting medically accurate and evidence-based education, and implementing youth development strategies.

In 2009, the DHSS Adolescent Health Team assessed changes since 2006 in services/programs for adolescents. The results indicated significant increased capacity and maintenance of collaborative work across DHSS programs to address the health needs of adolescents and young adults (ages 10-24). Few programs/services had ended. CASH members will collaborate on the broad scope of adolescent health and education issues.

Continue Children's Mercy Hospital contract for adolescent medicine and health consultation services and ADOLESCENT SHORTS.

DHSS will co-sponsor trainings to promote healthy youth development, adolescent-friendly health care, teen pregnancy prevention and health issues. A new training, Valuing Adolescents, will be offered.
Adolescent Health Web page will continue.

DHSS will administer State Title V, Section 510 Abstinence Education Grant by contracting with 9 school and community organizations to provide abstinence education for 12-14 year-olds, positive youth development programs and parent/family/adolescent sexuality education and communication strategies.

MCBHV, Building Blocks, and Alternatives to Abortion providers will continue to educate young women on birth spacing to decrease teen pregnancies and improve the health of the mother and newborn. Building Blocks of Missouri is continually referenced by Healthy Teen Network and Brookings Institute as a best practice and cost-effective measure.

Newborn Health provides brochures/literature on importance of preconceptual care.

MCH Coordinated Systems will offer consultation and technical assistance to LPHAs to improve local systems ability to address teen pregnancy prevention through evidence-/research-based methods and best practice models.

OMH will produce and distribute health education materials in selected St. Louis zip code areas. The target audience may include female teens.

BHI will provide teen births from vital statistics system and number of female teens aged 15-17 from population estimates.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	14	14	30	35	31.6
Annual Indicator	14.0	28.6	28.6	28.6	28.6
Numerator	10055	18686	18795	19355	19252
Denominator	71823	65337	65718	67677	67314
Data Source					Missouri Oral Health Survey

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	32.6	33.6	34.6	35.6	36.6

Notes - 2008
Source: Missouri Oral Health Survey conducted every five years. The most recent data from the 2005 Missouri Oral Health Survey is used as proxy for 2008. Denominator is 3rd grade Fall enrollment figure for 2007-2008 school year, from the Missouri Dept of Elementary & Secondary Education. Numerator is estimated based on the 2005 percentage.

An annual increase of 1% starting from 2005 was chosen to create future objectives for 2009-2013, with consideration of both past performance and discussions with the DHSS Oral Health Program.

Notes - 2007
Missouri Oral Health Survey was conducted every five years. The most recent data from the 2005 Missouri Oral Health Survey is used as proxy for 2007. Denominator is 3rd grade Fall enrollment figure for 2006-2007 school year. Numerator is estimated based on the 2005 percent.

An annual increase of 1% starting from 2005 was chosen to create future objectives for 2008-2012, with consideration of both past performance and discussions with staff from the Oral Health Program, Missouri Department of Health and Senior Services.

Notes - 2006
Numerator estimate for 2006 is based on 2005 Missouri Oral Health Survey. Denominator is 3rd grade Fall enrollment figure for 2005-2006 school year.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

a. Last Year's Accomplishments
In March 2007, OHP offered oral health education PowerPoint presentations designed specifically for Kindergarten-High School Seniors and are accessible for free downloading by school health nurses or teachers as well as by other health care/child care professionals in conjunction with health curriculum. These presentations have been very well received nationally as well as internationally. Other states have been given permission to adapt the presentations for their populations. The K-12 Oral Health Education Curriculum continues to be well received throughout the world including Canada, Marshall Islands and University of Sulaimani-Kurdistan Region-Iraq. Within the United States, the Native American Professional Parent Resource Center adapted the curriculum to their population. Other states oral health professional associations such as Connecticut State Dental Association and the American Dental Hygienist Association have posted the curriculum on their website. Other states oral health programs such as Oregon Oral Health Outreach, Wisconsin Division of Public Health, and Delaware Division of Health have also provided positive feedback. At least 15 schools within the state of Missouri are using this curriculum - at this time actual number of schools utilizing this curriculum is unavailable as the curriculum can be downloaded free of charge on the department website.

Elks Mobile Dental Program continued to provide primary clinical and preventive dental services to special health needs population. Elks Mobile Dental Program received PSP training during 2007 and continued to reinforce good oral hygiene and education for CSHCN and mental retardation and developmental disabilities. Elks Mobile Dental Program is collaborating with the Oral Health Program, the Missouri Primary Care Association, federally qualified health centers, Department of Mental Health, Missouri Planning Council and other partners to develop and implement a training program available to dental health professionals on how to provide dental care to special health care needs population. The training to the dental health professionals was conducted in April 2009 in a Train the Trainer workshop. Those dental professionals that participated in this training are now able to assist in training other dental professionals across the state in the care of special health care needs population. In addition, a curriculum is being developed to train Department of Mental Health staff, caregivers, and parents on oral health care hygiene and to participate in how to best help the patient through the process of receiving dental care. This curriculum was provided to the Department of Mental Health staff in March/April for implementation. These initiatives should help to improve access of care to the special health needs population as well as assist caregivers with training on oral health hygiene.

Discussions with DMH address ways to increase access to dental care for CSHCN. Dental care access survey was conducted in 2007 with DMH MRDD Regional Centers and SHCN population; results indicate 41% have not seen a dentist in last 12 months; 44% have unmet dental needs. Barriers are cost, no dentist to accept patient, fear of treatment and transportation.

MCH Coordinated Systems used Title V funds to support local efforts to improve oral health and the use of protective sealants by offering technical assistance and consultation. Focus continued on best practice efforts within collaboratives with schools, private providers and local coalitions to enhance local systems capacity to address the issue of oral health.

School Health Services Program funded School Nurse positions in areas of rural Missouri with high poverty and limited resources. All school contractors track number of school-age children with regular source of dental care and partner with community-based services to increase number of children seen by a dentist. Nine school contracts track number of children with a dental sealant and partner with community-based services to provide sealant services at school or in the community. School Nurses use SHACs as resource to assist in developing outside systems to address availability and accessibility of services. 9,620 school children were referred for dental care.

CCHC Program is educating child care providers and young parents of children in child care on the importance of oral health in young children including the benefits of dental sealants.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Elks Mobile Dental Program provided primary clinical and preventive dental services to CSHCN and other vulnerable children populations	X		X	
2. Patients needing comprehensive care were referred to Truman Medical Center with all expenses paid by the Elks	X		X	
3. Missouri schools participated in the FMR and began transitioning to PSP			X	
4. Head Start, Early Head Start, pre-school and elementary school children received screenings, education, referrals and fluoride varnish applications to prevent/control growth of caries/cavities through Oral Health Preventive Services		X	X	
5. Missouri population on public water systems had access to fluoridated water systems			X	

6. Cadre of Registered Dental Hygienists in communities aided in the development of oral health interventions and acted as liaisons in regard to oral health issues, including public water fluoridation			X	
7. Missouri Oral Health Preventive Services Initiative			X	
8. Fourth annual Oral Health Summit for Missouri				X
9. OHP provided oral health radio spots statewide focusing on good oral health habits for children/youth			X	
10. MCH Coordinated Systems had contracts with LPHAs that developed community specific interventions increase the percent of third grade children who have received protective sealants		X	X	X

b. Current Activities
Oral Health Advisory Group helps evaluate DHSS oral health programming and provides guidance in public health interventions.

About 57,194 children in 253 schools participated in FMR during 2008-09 school year. The 2009-10 school year will be the final year FMR will be offered; many schools are working to transition to PSP for the next school year.

Discussions with DMH have led to initiatives to help improve the oral health of cyshcn and increase access to care.

Elks Mobile Dental Program continues their services.

Missouri Donated Dental Program provides primary and preventive dental services to cyshcn and mrdd. Spin toothbrushes were provided to SSSHs to assist with oral hygiene. PSP will be implemented in SSSHs in 2008. PSP was implemented in all 31 Schools for Severely Disabled in Missouri during the 2008-09 school year with 1,100 cyshcn participating.

OHP provided DNR data for updating CDC's WFS in 2007 and is working on 2008 updates.

MCH Coordinated Systems district staff offer consultative support and technical assistance to the SHS program, local school nurses and local public health agencies.

School Health Services continues activities previously described. School Nurses used SHACs as resource to develop outside systems for availability and accessibility of services. This year contractors elected to implement oral health promotion curriculum or increase children participating in program promoting topical fluoride. Schools are transitioning to the Fluoride Varnish program.

c. Plan for the Coming Year
School Health Services Program will continue to fund school health services contracts in small rural areas of Missouri. These contractors are required to be advised by a SHAC comprised of community and school members. Many SHACs have accepted the challenge of working with the community to find dental services for children. One of the performance measures in the contract is to increase the percent of children receiving topical fluoride.

MCH Coordinated Systems district staff will continue to offer consultative support and technical assistance to School Health Services Program, local School Nurses and LPHAs wishing to address oral health and dental sealants in their communities.

CCHCs will offer adult education and children's health promotion programs on dental health and appropriate dental health habits. Information on the Missouri dental sealant program will be given.

Schools that participated with FMR program in school year 2008-2009 will be transitioned to Oral Health PSP by 2011. PSP includes screenings, education, toothbrushes, referrals for care and fluoride varnish applications. During 2007-08 school year schools were alerted that the FMR program would be phased out and were encouraged to transition to PSP. Efforts are ongoing to implement PSP in schools, early childhood learning centers and Head Start as well as WIC programs throughout the state. For school year 2008-09, over 34,000 children participated in PSP. For school year 2009-2010, the goal is to provide this oral health preventive care to over 50,000 children. PSP Oral Health Consultants will continue to work with LPHAs to implement PSP in their communities.

OHP implemented PSP in all Missouri Schools for Severely Disabled during school year 2008-09 and plan to continue in 2009-2010 school year. Donated Dental Program will continue to provide primary and preventive dental services to the SHCN population. Donated Dental Program is currently facing a growing waiting list due to needs of this population. DMH continues to work with MPCA and FQHCs to explore additional avenues for providing dental services to the developmentally disabled population.

The five-year 3rd grade oral health screening will be conducted in the 2009-2010 school year. This will include a random sampling of schools with a convenience sample to include 6th grade children.
OHP will be working with CDC to update WFRS.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	3.9	3.3	3.7	3.5	3.5
Annual Indicator	4.4	3.7	3.6	3.6	3.1
Numerator	50	43	42	42	36
Denominator	1141490	1162408	1161417	1169228	1169228
Data Source					MO DHSS. Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	3.1	3	3	2.9	2.9

Notes - 2008
Source: Missouri Information for Community Assessment (MICA) Death, Missouri Vital Statistics, Bureau of Health Informatics, MO DHSS. 2008 provisional death data as of April, 2009. 2008 final death data will be available in November, 2009. 2008 denominator of population estimate under 15 years of age is not available yet, and 2007 population estimate is used as a proxy for 2008.

2008 population estimate for specific age groups will be available in November, 2009.

The death rate due to MVC among children under 15 in MO decreased from 3.6 in 2007 to 3.1 per 100,000 in 2008, though the decrease was not statistically significant. A gradual decrease of 0.1 per 100,000 for every two years was chosen to create objectives 2009-2013, based on a combination of trend analysis on data 1999-2008, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) Death,
and Bureau of Health Informatics, MO DHSS. 2007provisional death data as of April 28, 2008. 2007 final death data will be available in November, 2008. 2007 denominator of population estimate under 15 years of age is not available yet, and 2006 population estimate is used as a proxy for 2007. 2007 population estimate for specific age groups will be available in November, 2008.

Future objectives 2008-2012 were based on trend analysis on data 1999-2007, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2006
Data source is Missouri Information for Community Assessment (MICA).
2006 provisional numbers used for denominator as of July 2, 2007.

Annual performance objectives for 2007-2011 based on logistic regression on 2001-2005 data. The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

a. Last Year's Accomplishments
All school health contractors used CDC School Health Index on Safety Policies and Environment to form multidisciplinary committees to assess healthy/safe school environments. Two-year plans were developed to address safety issues identified by multidisciplinary committees of school and community members. Plans implemented at the community level included seat belt safety, car seat information, focus on child safety seats for children under 9, playground safety and safe driving tips via school newsletters and classroom presentations. School Nurses were provided with information tips and sample presentations to use at parent meetings.

IVPP partnered with MIVPAC to reduce rate of mortality to Missouri residents 14 years and younger caused by motor vehicle crashes.

IVPP with MIVPAC worked on comprehensive Strategic Planning on Injury and Injury Data Book with focus on this age group.

IVPP supported 8 SAFE KIDS Coalitions for 50 counties to provide primary injury prevention interventions targeted to children from birth through 14 years of age.

IVPP evaluated contract to administer Missouri SAFE KIDS Coalition, provided local coalitions technical assistance, assessed SAFE KIDS expansion of regional injury and violence prevention coalitions web that takes leadership for assessment and policy development for all injury causes within a region.

IVPP supported UMC School of Medicine contract to conduct Think First Missouri activities to provide primary injury prevention interventions through school assemblies and reinforcement programs, specifically related to preventing head and spinal cord injuries.

SAHC continued to represent DHSS on the Governor's Substance Abuse Prevention Initiative Advisory Committee to build prevention capacities and infrastructure at state/community levels

focusing on risky drinking behaviors among 12-25 year olds. Proxy measures were alcohol-related emergency room visits, motor vehicle crashes and juvenile offenses. Funding from SAMSHA supported the planning and implementation grants to community coalitions to address youth alcohol-related priorities.

ADOLESCENT SHORTS addressed Missouri's Graduated Driver License Law and best practices to provide teens needed experience to be safe drivers.

2008 MCH Institute showcased best practices regarding child passenger safety, SAFE KIDS, youth driven drive smart campaigns and education.

The DHSS-sponsored Home Visiting and Alternatives to Abortion programs provide car seats and booster seats to mothers/families enrolled in these programs and provided education on their use.

MCH Coordinated Systems contracts with LPHAs focus on addressing 1 of 3 MCH health priority health issues. Reducing Intentional and Unintentional Injuries is the focus of 40 contracts with LPHAs with population-based services and community capacity building initiatives. Community collaborations to address this issue have been formed or enhanced with schools, law enforcement, SafeKids Coalitions, Missouri Department of Transportation, businesses, child care providers, parents and other partners. These collaboratives reviewed data around this issue in their communities and began planning for the implementation of community-based best practice interventions to promote healthy choices, decision making, advocating for policy changes and general injury prevention educational campaigns. Six regional trainings for contractors were offered in the fall, which included a workshop by DHSS community development staff, "How to Engage Communities to Improve Health". In the spring, a two-day state-wide training, 2008 MCH Institute, provided information for contractors, school nurses, and their community partners with best-practice models already being implemented within Missouri communities on addressing motor vehicle safety and other injury prevention strategies. Sessions on working with community collaboratives were also presented. LPHAs, MCH program staff, School health, Adolescent Health, Missouri SafeKids Coordinator and other partners participated on the planning committee.

The CCHC Program provided 24 hours of group education/consultation to child care providers on the topic of child passenger safety. In addition, 14 programs were provided to young children on this topic.

BHI provided the data to produce this measure from the vital statistics system.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Injury and Violence Prevention Program works closely with the Division of Highway Safety to assure training is available to certify child passenger safety technicians and CPS trainers			X	
2. SAFE KIDS Coalitions conducted car seat check ups, safety /injury prevention events; inspected child passenger safety seat installation; & distributed child passenger safety seats, booster seats, bicycle helmets, gun safety locks & smoke detectors			X	X
3. Contracts were offered to eight local SAFE KIDS Coalitions to provide primary injury prevention interventions targeted to children from birth through 14 years of age			X	X
4. At school assembly programs, conferences and exhibits Think First Missouri provided primary injury prevention interventions for children and adolescents specifically related to preventing head and spinal cord injuries			X	

5. School Health Index: A Self Assessment and Planning Tool		X	X	X
6. Conference for School Nurses, public health professionals and injury and violence prevention practitioners			X	X
7. MCH Coordinated Systems supported community systems development/community-based interventions with 40 LPHAs to address unintentional and intentional injury		X	X	X
8. Local agencies implemented strategies to reach families with children for car seat/seat belt safety		X	X	X
9. CCHCs educated child care providers with standardized injury prevention materials such as passenger vehicle safety, poison prevention, safe sleep, playground safety, etc., in most areas of the state		X	X	X
10. BHI provided vital statistics to produce data for this measure				X

b. Current Activities
IVPP continues to partner with: 9 local SAFE KIDS Coalitions; School Health Program; MIVPAC; Think First Missouri; MO Coalition for Roadway Safety to provide injury data for MO's Blueprint for Safer Roadways; LPHAs, district health educators, MCH programs, School Health Nurses, Public Health professionals and injury and violence prevention practitioners.

IVPP is completing Web site and activity for this group.

Contractors in School Health Services Program use the CDC "School Health Index" to involve school and community to identify strengths and weaknesses in school policies and program related to safety and develop plans to address areas identified.

DHSS Adolescent Health and CASH address related adolescent health system capacity priorities related to this performance measure.

Home Visiting and Alternatives to Abortion provide car seats and booster seats. Reducing Intentional and Unintentional Injuries is focus of 41 MCH contracts. Schools, law enforcement, businesses, child care providers, parents and others implement best practices to promote injury prevention.

Home Visiting collaborated with the Newborn Health and Unintentional Injury programs to develop educational cards on car seat safety for pregnant women, infants, toddlers, children and adolescents.

The CCHC program educates child care providers on the topic of injury prevention such as passenger vehicle safety, poison prevention, safe sleep, playground safety, etc.

BHI provided the data.

c. Plan for the Coming Year
IVPP will partner with 9 local SAFE KIDS Coalitions and make efforts to reestablish coalition in Central Missouri region to provide primary injury prevention interventions targeted to children from birth through 14 years of age.

IVPP will partner with MIVPAC to reduce rate of mortality of residents 14 years and younger caused by motor vehicle crashes.

IVPP with MIVPAC and St. Louis University School of Public Health, will continue work on comprehensive Strategic Planning on Injury and an Injury Data Report with focus on this age group.

IVPP will partner with Missouri Coalition for Roadway Safety to provide injury data to assist with Missouri's Blueprint for Safer Roadways. IVPP and Adolescent Health Program are participating in MoDOT Highway Safety Youth Summit collaboration to plan and implement 2009 conference and regional strategies to strengthen coordination of programs among state and community organizations.

IVPP will complete Web site that will serve as resource to focus and launch prevention activities for this age group.

IVPP will partner with LPHAs, District Health Educators, MCH Programs, School Health Nurses, Public Health professionals and injury and violence prevention advocates and practitioners throughout state to address issues of common interests.

DHSS-sponsored Home Visiting and Alternatives to Abortion programs will provide car seats and booster seats to mothers/families enrolled in these programs and will provide education on their use.

BHI will provide deaths due to motor vehicle crashes from vital statistics system and number of children aged 14 and younger from population estimates.

MCH Coordinated Systems contracts with LPHAs address one of three MCH health issues. Reducing intentional and unintentional injuries is the focus of some contracts with population-based services and community capacity building initiatives addressing injury prevention in MCH population. Collaborative efforts with schools, law enforcement, businesses, child care providers, parents and other partners will implement and evaluate community-based best practice interventions to promote healthy choices, decision making, advocating for policy changes and general injury-prevention educational campaigns. Interventions include health and safety fairs, community educational campaigns, child safety seat technician training for local public health staff, promotion and education related to booster seat laws, education to child care providers and distribution of motor vehicle child safety devices among others.

CCHCs will offer education and consultation to child care providers, parents of children in child care and young children on child passenger safety (CPS).

Newborn Health will disseminate four child safety seat and safety belt postcards demonstrating proper safety seat and safety belt use for pregnant women, infants, toddlers, boosters/older children and adolescents.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			32	34	34.9
Annual Indicator	29.9	29.9	34.7	30.5	30.5
Numerator	23235	23235	28229	23957	24813
Denominator	77709	77709	81353	78547	81353
Data Source					National Immunization Survey
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	35.1	35.3	35.5	35.7	35.9

Notes - 2008
Breastfeeding percentage is from CDC's National Immunization Survey. 2008 data (2006 birth cohort) is not available yet, 2007 provisional data (2005 birth cohort) was used as proxy for 2008. 2007 final data will be available in August 2009. Denominator is number of 2006 births in Missouri from MICA-Births, MO vital statistics.

The percent of mothers who breastfed their infants at 6 months of age in Missouri showed a gradual increase from 2003 to 2006. Although the 2007 provisional data showed a decrease compared with the 2006 data, the decrease was not statistically significant. Objectives 2009-2013 were based on a combination of final data 2003-2006 and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
Breastfeeding percentage is from CDC's National Immunization Survey. 2007 final data are not available yet, and the data collected in 2006 (2004 birth cohort) were used as proxy for 2007 data. 2007 final data will be available in August 2009. Denominator is number of live births in Missouri in 2005.

The percent of mothers who breastfed their infants at 6 months of age in Missouri showed a gradual increase from 2003 to 2006. An annual increase of 0.2% was set to create objectives 2008-2012 based on past performance and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2006
Breastfeeding percentage of 32.6%, +/- 4.2%, is from CDC's National Immunization Survey in 2005. 2006 breastfeeding data not yet available. Denominator is number of live births in Missouri during 2006.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

a. Last Year's Accomplishments
Breastfeeding educational Web site was available to healthcare professionals for continuing education.

CDC funded a state plan to prevent obesity. Breastfeeding focus groups were conducted in St. Joseph, MO, as part of an obesity intervention activity. An evaluation was completed of the focus groups and a decision will be made in 2008 on what intervention to use based on focus groups.

Program updated Web-based breastfeeding curriculum for schools of medicine, nursing and dietetics. Additional updates are planned.

Program conducted month-long statewide promotional project including a breastfeeding message. Fiscal year 2007 message was Breastfeeding Support: Ties That Bind A Healthy Community focusing on community acceptance that breastfeeding is the gold standard for infant feeding.

Program expanded its evidence-based WIC Breastfeeding Peer Counseling Program that is part of WIC services in 49 agencies. Statewide initiative provided over 75 trained peer counselors to support breastfeeding mothers. Breastfeeding Peer Counseling mandatory workshop was provided to peer counselors to help promote and support breastfeeding within WIC.

Lactation rooms were included in Worksite Wellness plans for DHSS strategic plan and expansion of these rooms to all state agencies.

USDA funds were used for the Breastfeeding Peer Counseling Program to promote and educate prenatal and postpartum women, WIC moms.

Baby Your Baby Web site (www.dhss.mo.gov/babyyourbaby) continues to provide information for pregnant women, their families and communities on healthy pregnancies and healthy babies. Site included wide range of topics including prenatal care, breastfeeding, immunizations, well child checkups and special health care needs. This Web site will remain active through January 2013.

Home Visiting programs provided breastfeeding education to clients seen for prenatal services; provided breastfeeding support for post-partum clients; referred mothers to lactation consultants and DHSS-supported peer counselor groups as indicated and provided incentives for mothers who chose to breastfeed.

Child Care Health Consultants provided technical assistance and consultation for child care providers on being supportive of mothers continuing breastfeeding following return to the workplace.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Statewide breastfeeding promotion project including media campaign		X		
2. Enhancement of Breastfeeding Peer Counseling Program		X		
3. Continuation of Web-based curriculum on breastfeeding available to students in healthcare field		X		X
4. Lactation Rooms in MO State Office buildings		X		
5. Missouri Council on the Prevention and Management of Overweight and Obesity Plan			X	
6. Home Visiting and Newborn Health programs provided breastfeeding education			X	
7. Child Care Health Consultants provided technical assistance and consultation for child care providers on being supportive of mothers continuing breastfeeding following returning to the workplace		X		
8.				
9.				
10.				

b. Current Activities

Continues to:
--enhance and support 49 WIC Breastfeeding Peer Counseling agencies.
--provide breastfeeding education to 118 WIC agencies.
--encourage development of evidence-based strategies for local agency breastfeeding interventions.

--evaluate Breastfeeding Education and Awareness Project with MO Chapter of AAP.
--support hospitals as they adopt evidence-based maternity care practices to promote, protect and support breastfeeding.
--evaluate effectiveness of evidence-based maternity care practices to increase breastfeeding initiation/continuation and recommend implementation of best practices.
-- Proclaim August as MO Breastfeeding Month and conduct marketing campaign portraying breastfeeding as the preferred method of infant feeding to be prepared in case of emergency.
--work with worksite wellness team to encourage employers to consider lactation room.
--work with Child Care regulation team on developing curriculum for Breastfeeding Friendly Child Care centers.
--Provided training for healthcare providers to prepare for the IBCLC exam in July 2009.

Baby Your Baby Web site continues to provide information as described above.

Home Visiting programs and Newborn Health continue breastfeeding education and support.

Alternatives to Abortion providers are given resource information to share with pregnant women on benefits of breastfeeding and referral sources for breastfeeding assistance.

CCHC educates child care providers on benefits of supporting breastfeeding families in child care.

c. Plan for the Coming Year
Breastfeeding Program will work with MOCAN to help increase initiation and duration rates of breastfeeding through grants awarded to specific communities.

Breastfeeding Program will:
--work in partnership with AAP to develop a plan to help promote, educate and increase breastfeeding initiation and duration; educating nurses, doctors and hospital staff with up-to-date information about breastfeeding and developing "breastfeeding friendly" model that can be successful.
--work to educate nurses, Lactation Consultants, peer counselors, and physicians on the importance of continuation of breastfeeding exclusively for 6 months or longer. A conference will be held in September 2008 to promote this message.
--work to update Web-based lactation education program and to obtain continuing education credits for those who utilize the site.
--educate all Missourians regarding the importance of breastfeeding and benefits to mothers, infants, families and employers. Information is being made available regarding Missouri laws concerning breastfeeding.
--collaborate with DHSS-sponsored Home Visiting programs to improve knowledge of the home visitors on breastfeeding. Data collected through home visiting databases will be used to identify those programs with lowest incidence of breastfeeding and to target those mothers and home visitors.

Alternatives to Abortion contractors will be educated on the importance of breastfeeding to newborn infant and advantages to both mother and infant. Home visiting contractors will continue to educate pregnant women on the advantages of breastfeeding and to assist mothers in proper techniques and refer to the WIC Peer counselors or lactation consultants as needed.

Educational materials and information on WIC Peer Counselor program have been provided to contractors. Breast pumps can be purchased for participants if there is no other source of funding.

Baby Your Baby Web site (www.dhss.mo.gov/babyyourbaby) will provide information for pregnant

women, their families and communities on healthy pregnancies and healthy babies. It includes a wide range of topics including prenatal care, breastfeeding, immunizations, well child checkups and special health care needs. This Web site will remain active through January 2013.

CCHCs will provide continued education to child care providers and parents on support of breastfeeding families in child care.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	97	99	99	99	99
Annual Indicator	99.2	99.9	96.6	97.2	98.6
Numerator	77084	78487	78576	79580	79725
Denominator	77708	78547	81353	81883	80868
Data Source					Missouri Newborn Hearing Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	99	99	99	99	99

Notes - 2008
Source: Missouri Newborn Hearing Screening Program, DHSS Bureau of Genetics and Healthy Childhood. Final 2008 data for number screened will be available January, 2010. Numerator is provisional number of newborns screened before discharge. Denominator is number of 2008 provisional live births from DHSS Vital Statistics. Final birth number will be available October, 2008.

Notes - 2007
Numerator number of newborns screened before discharge in 2007 is provisional data, and final data will be available by the end of December 2008. Denominator is number of live births in Missouri in 2007 (provisional data as of June 24, 2008). 2007 final birth data will be available in October 2008.

2008-2012 performance objectives set at 99.0%. There may be annual variations in the percent of newborns who are screened (including indicators > 100.0%) since mothers delivering babies in MO or IL may have their babies screened in MO, or vice versa.

The decrease in the percent of newborns screened prior to discharge since 2006 is due to upgrades implemented in the data management system that allow the system's reports to accurately reflect the actual number of infants screened prior to discharge.

Notes - 2006
2007-2011 performance objectives set at 99.0%. There may be annual variations in the percent of newborns who are screened (including indicators > 100.0%) since mothers delivering babies in MO or IL may have their babies screened in MO, or vice versa.

The decline of the % of newborns screened from 2005 to 2006 was due to a data retrieval problem with the MO Department of Health and Senior Service's computer system (MOHSAIC) that has now been fixed to accurately reflect the %of newborns screened.

a. Last Year's Accomplishments
DHSS continued to contract in 2008 with MSU to provide technical assistance, training and consultation services to birthing hospitals and centers operating universal newborn hearing screening programs.

MNHSP worked with DESE in two areas. First, the MNHSP continued to work with DESE to ensure SPOEs request consent to share personally identifiable information from parents of newborns diagnosed with hearing loss in order to allow the sharing of information related to Part C intervention as a result of newborn hearing screening. Second, MNHSP continued to work closely with DESE to ensure the Pilot Hearing Loss Service Coordination Project is successful and to explore possibilities for putting into regular, statewide use in 2008.

MNHSP also continued its outreach into Mennonite, Amish and other homebirth communities through training and equipment loans in order to ensure babies in those communities receive a hearing screen.

A Web-based electronic birth certificate which will include the ability to submit hearing screening results to DHSS is continuing to be developed to facilitate more timely reporting of screening results. The hearing portion is scheduled to be in place by January 1, 2010 or shortly thereafter.

ITSD fixed many aspects of the case management system and reporting ability of the newborn hearing application within MOHSAIC.

MNHSP worked with ITSD to improve the current data management and report system to allow reliable statistics based upon all hearing cases in the system. BHI conducted an analysis of the Missouri EHDI system.

MNHSP initiated a pilot project in southeast Missouri to reduce lost to follow-up following a refer result. The pilot involves changes in the way families and PCPs are notified of the need for follow-up and requires changes in procedure in both the pilot hospitals and in the MNHSP follow-up unit.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Missouri Newborn Hearing Screen Program screenings conducted		X	X	X
2. Pilot Hearing Loss Service Coordination Project		X	X	X
3. DESE information shared with HFY/GHC			X	X
4. A Web-based birth system is being developed which will facilitate timelier reporting and an ability to see completeness of screening by hospital				X
5. MOHSAIC Case Management and statistical reports repairs made				X

6. Evaluation of Missouri EHDI system by DHSS Health Informatics				X
7. Consultant Audiologist provides monitoring and training expertise				X
8. Reduction in loss-to-follow-up following a refer pilot project		X	X	X
9.				
10.				

b. Current Activities

In December 2008, MNHSP completed evaluation of the SC Pilot Project which, with DESE, pairs newborn hearing loss SC with First Steps SC during first visit to family of infant diagnosed with permanent, bilateral severe to profound hearing loss. Family responses were positive but few. MNHSP sent additional survey to SCs. 100% of SCs found a significant benefit to working with specialized SC when dealing with families of children diagnosed with permanent hearing loss. Implementation of electronic birth certificate projected January 2010. It is expected electronic submission will improve hospitals' reporting rates and MNHSP ability to determine if initial hearing screenings occurred prior to baby's hospital discharge. MNHSP, DHSS Vital Records and DHSS ITSD staff working to ensure implementation.

DHSS continues MSU contract in 2008 for technical assistance, training and consultation services to birthing hospitals and centers operating universal newborn hearing screening programs and work with DESE to obtain parental permission to share identifiable information and early intervention details for children identified with permanent hearing loss through MO EHDI system.

MNHSP recent pilot project to reduce ‘lost to follow-up' following "refer" result. Changes the way families and PCPs are notified of needed follow-up and requires procedure changes in the pilot hospitals and in the MNHSP follow-up unit. Project will be broadened to include more hospitals in the summer of 2009.

c. Plan for the Coming Year

MNHSP will implement or continue the following activities in FY10:
--Continue site visits to hospitals that do not regularly send rescreen results to the program.
-- Expand pilot program to up to fifteen additional hospitals in which poorly performing hospitals will use a script to remind parents of the importance of follow-up, make the appointment for the newborn and send notification of the appointment to DHSS.
--Continue appointment reminder phone calls made by DHSS staff to the identified families.
--Continue efforts to work with ITSD to ensure hearing screening data management application is accurate and capable of producing meaningful reports related to loss to follow-up and statistical relevance.

Based upon success of the expanded Service Coordination Pilot Project, the MNHSP will seek to continue the project by expanding the pilot or by implementing it as a permanent feature of the Missouri Early hearing detection and intervention system. The pilot project, in collaboration with DESE, pairs newborn hearing loss service coordinator with First Steps service coordinator during initial visit to a family with infant diagnosed with permanent, bilateral severe to profound hearing loss in western and central regions of Missouri.

By January 2010 it is expected that hospitals will have the means to submit initial hearing screening results to MNHSP via the new electronic birth certificate. Once implemented, it is expected that the ability to submit results electronically will improve the hospitals' reporting rates and the ability for the program to determine if initial hearing screenings occurred prior to a baby's discharge from the hospital. MNHSP will work closely with DHSS Vital Records and ITSD staff to ensure implementation.

In collaboration with Bureau of Genetics and Healthy Childhood, Bureau of Health Informatics and Information Technology Services Division, MCH Epidemiology Response Team proposed and facilitated data linkage of Missouri's Newborn Hearing Screening Data with birth files from 2006-07. The linked data will be analyzed to identify subgroups and geographic areas at high risk for loss to follow-up for audiological evaluation for newborn hearing loss. The findings will help the program optimize resources and efforts for targeted interventions to improve follow-up on use of audiological evaluation.

The School Health Services program began in 2009 surveying all public schools in Missouri related to number of children identified for the first time with a hearing loss as a result of a school based hearing screening.

The Home Visiting and Alternatives to Abortion providers will be educating their clients on newborn screening.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	4.7	8.1	8.2	7.9	10.5
Annual Indicator	7.4	7.7	9.1	10.5	10.5
Numerator	103000	106000	127000	151000	151000
Denominator	1386910	1378232	1398000	1442000	1442000
Data Source					US Census Bureau. Current Population Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	10.4	10.4	10.3	10.3	10.2

Notes - 2008
Source: US Census Bureau. Current Population Survey (CPS), Annual Social & Economic Supplement (ASES), 2008. The 2008 survey reflects insurance coverage in 2007. Denominator is population estimate of persons under 18 years of age.
Data from the CPS, ASES, 2009 will be available at the end of September 2009.

The percent of children without health insurance in Missouri showed a gradual increasing trend from 2001 to 2007. In light of potential policy changes and economic factors, it is difficult to make predictions on this measure. Objectives 2009-2013 were based on discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2008, Table HI05. The 2008 survey reflects insurance coverage in 2007.

The percent of children without health insurance in Missouri showed a gradual increasing trend from 2001 to 2007. In light of potential policy changes and various environmental factors, it is difficult to make predictions on this measure. Objectives 2008-2012 were set based on discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2006
2006 health insurance coverage data not available, yet - 2005 numbers from Health Insurance Coverage tables from Census Bureau's Current Population Survey used as proxy. http://pubdb3.census.gov/macro/032006/health/h05_000.htm

The percent of uninsured kids is conservatively predicted to drop by 0.3% per year, based on the yearly change seen in past rates from Census Bureau data. However, in light of impending Medicaid reforms in Missouri, it is difficult to make accurate predictions of the percent of uninsured children.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

a. Last Year's Accomplishments
Each School Health contract required an increase in percent and number of children with regular source of medical care on an annual basis.

School Health and Maternal Child Health Programs partnered with Heartland Centers at St. Louis University School of Public Health and DMH to provide 12 regional workshops based on BRIGHTFUTURES IN PRACTICE: MENTAL HEALTH to collaborate on children's mental health. Over 800 participated in Year One.

Home Visiting and Alternatives to Abortion program providers shared information with their clients on the availability of the SCHIP program for their children.

SHCN:
--maintained standard protocols for SCs to monitor status of MHN referrals and the ability to obtain participants' MHN status through data linkage with DSS.
--collaborated with other entities to promote adequate insurance for participants.
--distributed the Insurance Comparison Checklist and the Insurance Fact Sheet, which empowered families with the necessary resources to obtain adequate insurance. Both were available on the SHCN Web site, in Family Care Notebooks and at health fairs/conferences.
--trained SCs on how to assist potential participants in determining available resources for adequate insurance.
--collaborated with managed care organizations, SCBs, DSS, DMH and DESE to obtain information about CSHCN that transition within the systems of care.
--completed the CAT with SHCN participants, which included assessing adequacy of insurance.
--utilized electronic CAT database for statewide data collection consistent with federal data collection and compared participant data with data reported through national surveys.
--began Phase 2 of the statewide electronic database enhancement to focus on Financial Management.
--administered CSHCN-Hope Program (RSMo, CCS), which provides early identification and health services that included service coordination, diagnostic and treatment services involving medical care, hospitalization and aftercare to participants who require sub-specialty, specialty, preventive and primary care. Medicaid referral and enrollment, or verification of active enrollment, was required of all participants. ACM was provided for participants in the HCY through a

cooperative agreement SHCN maintained with DSS MHN. SHCN authorized the medical necessity of in-home nursing services and provided service coordination for participants.
--partnered with FVM and UMKC who received a grant to establish a FTF Health Information Center. The goal of the project is to provide information, training, and personal support to families of children and youth with special health care needs.
--partnered with UMKC who received a SIG. The goal of this project is to improve and sustain access to quality, comprehensive, coordinated community based systems of services for cyshcn and their families in Missouri.
--partnered with the UMC Thompson Center who received a Autism Grant.

MOCCRRN provided all families who requested child care referrals with MHN information. CCHC program provided assistance with locating a source of health care coverage for families upon request.

LPHAs targeted children without health insurance and assist families in obtaining health care coverage through partnerships with local schools, insurance providers and childcare facilities.

OHP continued support of FQHC services and sites expansion. With the support of OPCRH, at least three dental clinics were established in 2007-2008 or are being established with additional FQHCs requesting support. This will have a definite impact on improving access to dental care. FQHCs continue to add dental clinic sites.

Oral Health PSP included early childhood learning centers, Head Start and Early Head Start Programs and additional rural/urban school districts. OHP and SHCN along with DMH MRDD conducted oral health care access survey with the special health care needs population as explained in previous section. Discussions were held and are ongoing as to how to assure dental care access through Elks Mobile Dental Program, Donated Dental Services and other services/sites. These discussions have led to DMH collaborating with various partners in implementing initiatives to improve oral health in the special health care needs populations as explained in previous sections.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MOCCRRN and CCHCs' technical assistance and consultation to access health insurance and/or MHN provided		X		
2. School Health Services Program increased access to primary and preventive health care and CSHCN identified and referred into a system of care		X	X	
3. MCH Coordinated Systems contracted with LPHAs that developed community specific interventions to target risk factors such as children without health insurance			X	X
4. Home Visiting and Alternatives to Abortion program providers shared information with their clients on the availability of the SCHIP program for their children		X		
5. Baby Your Baby Web site included MHN and financial resources for pregnant women and children			X	X
6. OHP supported FQHC services; provided PSP services; collaborated on dental care access through Elks Mobile Units, Donated Dental Services, etc.	X		X	X
7. SHCN collaborated with other entities to promote adequate insurance for participants		X		X
8. Exchange of information conducted with MCOs, DSS, DMH and DESE for children transitioning within systems of care		X		X

9. Comprehensive Assessment Tool (CAT)		X		X
10. CSHCN-Hope Program provides early identification and health services including service coordination	X	X		

b. Current Activities
Contractors in the School Health Services Program continue performance measure to increase the percent/number of students whose health record indicates an identified health provider/clinic.

School Health Services continues outreach to families with no/inadequate health insurance by partnering with MHN in regional meetings with School Nurses and sponsoring Web-linked information during back-to-school campaigns.

Home Visiting and Alternatives to Abortion program providers share information with clients on the availability MHN.

SHCN:
-- continues the prior year's activities and evaluates and improves as necessary.
--maintains the DSS linkage to obtain participants' MHN status.
-- utilize statewide electronic SCA database.
--implementing Phase 2 of the statewide database to focus on Financial Management.
--partners with FVM and UMKC on the FTF Grant.
--partners with UMKC on the SIG.
--partners with the UMC on the Autism Grant.

MOCCRRN provides all families who request child care referrals with MHN information. Parent Central was added to MOCCRRN's Web site to provide resources and information to families. CCHC program works with families to locate health care coverage or appropriate health care as requested.

MCH Coordinated Systems continues to offer consultation and technical support to LPHAs and School Nurses addressing children without health insurance. Best practice interventions and research information related to linking families to local resources are shared with partners as needed.

c. Plan for the Coming Year
MOCCRRN will provide all families calling for child care referrals with information regarding MHN. Efforts address state priority need of improving mental health status of MCH populations.

CCHCs will provide information to child care providers and parents regarding access to MHN and community level resources related to coverage for health care.

MCH Coordinated Systems will offer consultation and technical support to LPHAs and School Nurses addressing children without health insurance. Best practice interventions and research information related to linking families to local resources will be shared with partners as needed.

SHCN will:
--maintain protocols and evaluate methods, to improve SHCN procedure for SCs to monitor participant's MHN status and attain participants' MHN status through DSS data linkage.
--use the SCA system.
--complete implementation of Phase 2 of the statewide electronic database enhancement to focus on Financial Management.
--begin development of Phase 3 of the electronic database enhancement which includes eligibility and participant management.
--collaborate with other entities to promote adequate insurance and distribute materials to

empower families with resources to obtain adequate insurance.
--collaborate with Department of Insurance, Financial Institutions and Professional Registration.
--persist in SC training to determine available resources for adequate insurance and collaborate with agencies to obtain information about cyschn population that transition within systems of care.
--complete integration of assessment data into all-inclusive participant database and continue statewide data collection using Web-based SCA in collaboration with participants to determine if they have adequate insurance.
--administer CSHCN Program.
--continue the cooperative agreement with DSS-MHD for ACM through the HCY Program.
--partner with FVM and UMKC on the FTF Grant.
--partner with UMKC on the SIG.
--partner with the UMC on the Autism Grant.

Alternatives to Abortion providers will share information with their clients on availability of MHN Program for their children.

School Health Services has performance measure to increase percent and number of students whose health record indicates an identified health provider or clinic. Outreach activities such as posters, letters to parents and personal conversations at school events occur to identify barriers to health care enrollment. Barriers will be addressed by school staff (School Nurses and Social Workers) and by infusing concepts of health literacy and cultural competency into school practices. Information is distributed to schools via E Newsletter to all School Nurses (School Nurse Update, new initiative in School Health Program). E-letter has potential to reach 1,400 School Nurses.

Building Blocks and MCBHV will share information on availability of MHN program for children with the parents enrolled in their programs.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			30	30	30
Annual Indicator	30.4	30.4	30.2	30.3	30.7
Numerator	17506	17506	16182	16665	18699
Denominator	57587	57587	53585	55001	60908
Data Source					Pediatric Nutritional Surveillance System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**

Annual Performance Objective	30.7	30.6	30.6	30.5	30.5

Notes - 2008
Source:CDC data tables from 2008 Pediatric Nutritional Surveillance System.

The 2008 data showed a slight increase in this measure compared with the 2007 data, though the increase was not statistically significant. Missouri WIC program has made some changes in the food package to provide healthier foods since 2002, and will implement the new WIC food package in October 2009. We expect to see a gradual decrease in the overweight rate among WIC children with our new food package and getting children more into physical activity.

Notes - 2007
Source: CDC. Data Tables of the Pediatric Nutrition Surveillance System (PedNSS), Missouri.

Although Missouri is being affected by the same social and demographic factors contributing to childhood obesity as the rest of the nation. As reducing obesity among children is a stated priority of the state, we intend to make every effort to make progress in this performance measure.

Notes - 2006
Data obtained from Pediatric Nutrition Surveillance System (PedNSS).

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

a. Last Year's Accomplishments
BHI produced data for the measure of children, ages 2-5 years, receiving WIC services with a BMI at or above the 85th percentile (considered to be overweight or at risk of overweight). This data was provided on the WIC Child MICA as two indicators: children at risk of being overweight, and children considered to be overweight. Inclusion of the "at risk of overweight" component, including historical data, was an addition to the WIC Child MICA. BHI also provided data for the "overweight" component of this measure for children ages 2-5 years and receiving WIC services on the Child Health Profile. The "at risk of overweight" component of this measure will be added to the Child Health Profile in the future.

MO was not able to achieve the 2008 objective despite efforts to improve the food package offered to children. Improvement is anticipated in 2009 as further changes to the WIC food package (no whole milk, less juice and more fruits and vegetables) will be implemented in October 2009.

The MCH Coordinated Systems contracted with 48 LPHAs addressing obesity reduction with their community partners. Promising practices or research-based approaches included interventions that involve local child care providers and Head Start facilities on policy changes related to physical activity and nutritional intake and/or increased organized physical activity programs. Additionally some incorporated age appropriate physical activity education, FIT WIC, into existing WIC clinics. At the 2008 MCH Institute, presenters from a local WIC agency provided information on how they implemented FIT WIC into their current program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. BHI produced data for the measure of children, ages 2-5 years, receiving WIC services with a BMI at or above the 85th percentile (considered to be overweight or at risk of overweight)		X		X
2. 48 LPHAs contracts addressing obesity with some incorporating physical activity education into existing WIC clinics		X		

3. Over 5,000 Childhood and Obesity Toolkits have been distributed through MOCAN for the assessment and treatment of childhood obesity.		X	X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
BHI continues to produce data for children ages 2-5 years receiving WIC services with a BMI at or above the 85th percentile for this measure and provides it on the WIC Child MICA. BHI continues to provide data for children aged 2-5 years at or above the 95th percentile on the Child Health Profile.

The MCH Coordinated Systems contracts with 48 LPHAs addressing obesity reduction. Promising practices or research-based approaches may include interventions that involve local child care providers and Head Start facilities on policy changes related to physical activity and nutritional intake and/or increased organized physical activity programs. Additionally some may incorporate age appropriate physical activity education into existing WIC clinics.

c. Plan for the Coming Year
BHI will produce data for children ages 2-5 years receiving WIC services, with a BMI at or above the 85th percentile for this measure; and will provide it on the WIC Child MICA and the Child Health Profile. BHI will update the Child Health Profile for prior years to correspond with the 85th percentile measure.

The MCH Coordinated Systems contracts with LPHAs address one of three MCH health issues. Reducing obesity in the MCH population is the focus of some contracts with population-based services and community capacity building initiatives addressing obesity on the local level. Promising practices or research-based approaches may include interventions that involve local child care providers and Head Start facilities on policy changes related to physical activity and nutritional intake and/or increased organized physical activity programs.

Breastfeeding provides optimal nutrition for infants and is associated with decreased risk for infant morbidity and mortality, as well as optimal growth and development for children. Studies have shown that promoting prolonged breast feeding may help decrease the prevalence of obesity in childhood. Since obese children have a high risk of becoming obese adults, such preventive measures may eventually result in a reduction in the prevalence of cardiovascular diseases and other diseases related to obesity. A contract with the Missouri Chapter of the American Association of Pediatrics enables the state to promote statewide breastfeeding information to obstetricians and pediatricians. This support will enable hospitals to provide mothers with the help they need to continue breastfeeding after leaving the hospital.

CCHC Program will continue to have obesity prevention education as a targeted health issue.

Additionally some may incorporate age appropriate physical activity education into existing WIC clinics.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			17	19	19.6
Annual Indicator		17.7	20.4	18.4	18.4
Numerator		13940	16591	15066	14880
Denominator		78549	81353	81883	80868
Data Source					Missouri PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	18	17.8	17.6	17.4	17.2

Notes - 2008
The 2008 estimated percentage of maternal smoking during the last 3 months of pregnancy is not available yet. The 2007 estimate based on the 2007 Missouri PRAMS is used as proxy for 2008. 2008 PRAMS data will be available January 2010. Denominator is estimated using the number of live births in Missouri, provisional 2008, as of April 2009. 2008 final birth data will be available in October 2009.

A gradual decrease in this measure over the next five years 2009-2013 is expected, with considerations of a slight decrease in smoking during pregnancy for two consecutive years 2007-2008 observed from the birth file, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
Missouri has participated in the Pregnancy Risk Assessment Monitoring System (PRAMS) since 2007. 2007 estimate of smoking during last 3 months of pregnancy from PRAMS is expected to be available by the end of December 2008. An estimated percent from the Missouri's pilot PRAMS survey (2005-2006 Missouri Pregnancy Related Assessment and Monitoring System, MoPRA) was used as a proxy for 2007. Denominator is estimated using the number of live births in Missouri in provisional 2007 as of April 28, 2008. 2007 final birth data will be available in October 2008.

Despite limited funding for tobacco prevention and cessation programs in Missouri, we intend to make every effort to make progress in this measure. An annual decrease of 0.4% was used to create objectives 2008-2012, with consideration of trend analysis on the measure smoking during pregnancy from the birth file and discussions with the Section of Healthy Families and Youth, MO DHSS.

UPDATE: 2007 data have been updated using the 2007 Missouri PRAMS data.

Notes - 2006
2005 estimate of smoking during last 3 months of pregnancy is based on a stratified sample of 1,535 women (10 out of 12 batches) responding to the Missouri Pregnancy Related Assessment

and Monitoring System (MoPRA), Missouri's pilot PRAMS survey.

The 2006 estimate is based on all 12 batches of MoPRA, a sample of 1,789 women.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

a. Last Year's Accomplishments
MCH Coordinated Systems contracts with LPHAs were renewed with three focus areas of injury, obesity and tobacco prevention with their community partners. 24 LPHAs are addressing tobacco prevention/cessation with contract funding, although other LPHAs are also addressing this issue with other funding sources. Contractors worked to develop or enhance their community partnerships and to decide on evidence-based/community-based interventions to impact this issue.

CCHC program provided group education to child care providers on the health risks of smoking or exposure to secondhand smoke.

Home Visiting and Alternatives to Abortion programs continued to assess all women enrolled in programs for smoking and educate mothers on dangers of smoking during pregnancy including dangers of secondhand smoke and effects on their infant and worked with the women to decrease the number who smoke using 5 as an intervention and refer women to Missouri's Quitline.

ATODPA advised health care providers of availability of medical consultation for health care providers.

The Missouri Model for Brief Smoking Cessation Training (MO Model) was offered in 2008 through a $18,100 March of Dimes grant awarded to ATODPA. The MO Model is an educational outreach to health care clinicians in support of comprehensive tobacco control program with women of reproductive age, particularly pregnant women. DHSS facilitated MO Model development in 2005 and its implementation in 2006, 2007 and 2008. Developed and presented by a research psychologist associated with UMC, the MO Model is based on the U.S. Public Health Services' five-step intervention (5 As) outlined in the CLINICAL PRACTICE GUIDELINE: TREATING TOBACCO USE AND DEPENDENCE and adopted by American College of Obstetricians and Gynecologists (ACOG). The MO Model also incorporates transtheoretical model on stages of change; motivational interviewing; current cessation pharmacotherapy; Missouri Tobacco Quitline for tobacco cessation and prevention of relapse; and techniques integrating proven cessation strategies into clinical setting. QuitLine (800-QUIT-NOW) is a free service and provides smoking cessation coaching, self-help materials and optional registration to a free supplemental online Web Coach.

Five MO Model trainings, consisting of one to two-hour trainings targeting physicians and healthcare providers were provided to 130 individuals through five medically-related societies (i.e. dental, dental hygienist, medical, and respiratory therapists). The one to two-hour trainings were offered with established groupings of healthcare providers: two medical societies, one dental society, one dental hygienist society and a respiratory therapist society at their annual conference. Pre-and post-training surveys and follow-up surveys of MO Model participants showed significant differences in knowledge and behavior change in terms of smoking cessation discussions with women and use of resources.

In addition to MO Model trainings, a presentation regarding smoking cessation techniques and highlighting the Missouri Tobacco Quitline was made at the 2007 Missouri Section ACOG meeting. "Evidence-Based Interventions to Help Women Quit Smoking" was well received by the 33 physicians in attendance.

Self-help materials on smoking cessation and educational brochures in English, Spanish, Vietnamese and Chinese are available.

BHI continued to develop a Web-based birth system to capture "last trimester of pregnancy" (National Center for Health Statistics terminology). It is anticipated these data will be collected in 2010 and will be available for analysis at a later date.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 51 contracts with LPHAs provided community-based interventions to reduce percent of women who smoke during pregnancy through infrastructure development, community interventions and direct services to pregnant women			X	X
2. Home Visiting programs educate all mothers on the effects of smoking during pregnancy and utilized the 5As to decrease smoking among those women who smoke		X		
3. Education about the impact of alcohol, tobacco and other drug exposure on pregnancy to health care providers practicing with at-risk populations		X	X	
4. GHC continued coordinated efforts to address smoking in women of reproductive age		X	X	
5. CCHC program provided group education to child care providers on the health risks of smoking or exposure to secondhand smoke		X		
6. Development continued on a Web-based birth system, to be in place by January 2010, that will capture 'last trimester of pregnancy'				X
7.				
8.				
9.				
10.				

b. Current Activities

MCH Coordinated Systems contracts with 24 LPHAs focus on preventing tobacco use among adolescents and women. Each has contractual obligation to utilize evidence-based interventions to reduce percent of women who smoke during pregnancy and infrastructure development. Many involve schools and communities to promote healthy lifestyle choices and outreach/education to local health care providers and best practice methods to address smoking during pregnancy. Policy changes have occurred in some local communities and schools.

Home Visiting programs training home visitors to promote smoking cessation and refer clients to Quitline.

5 MO Model, 1 to 2 hour trainings targeting physicians/healthcare providers were provided to 130 individuals through 5 medically-related societies. The 1 to 2 hour trainings were offered with established groupings of healthcare providers: 2 medical societies, 1 dental society, 1 dental hygienist society and a respiratory therapist society at their annual conference. Pre-and post-training surveys and follow-up surveys of MO Model participants showed significant differences in knowledge and behavior change in terms of smoking cessation discussions with women and use of resources.

Missouri Model Training will be offered as requested in FY2009 using MCHBG funding.

Self-help materials on smoking cessation and educational brochures in English, Spanish, Vietnamese and Chinese are available.

Progress continues to add smoking status by trimester to Web-based system.

c. Plan for the Coming Year

Alternatives to Abortion programs will continue to assess women enrolled for smoking and educate mothers on dangers of smoking and secondhand smoke during pregnancy and effects on their infant and will work with women to decrease number who smoke by referring women to Quitline and other smoking cessation programs.

Mo Model for Brief Smoking Cessation training will be offered to groups who request it using MCH Block grant funding continuing into 2010.

Quitline provides tobacco use cessation coaching, self-help materials, nicotine patches or gum for eligible callers, optional registration to free supplemental online Web Coach and expert consultation to health care providers with clinical questions.

Self-help materials on smoking cessation and brochures in English, Spanish, Vietnamese and Chinese addressing tobacco use in pregnant women will be available for health care providers and families.

DHSS-sponsored Home Visiting programs will continue to assess all women enrolled for smoking and educate mothers on the dangers of smoking and secondhand smoke during pregnancy and effects on their infant and will work with women to decrease number who smoke using 5 As intervention and refer women to Quitline.

MCH Coordinated Systems contracts with LPHAs will be renewed with preventing tobacco use among adolescents and women as a focus area. Some LPHAs are implementing and will be evaluating evidence-based interventions within their WIC clinics and through prenatal case management.

CCHCs will offer education to child care providers and young parents on risks of smoking and exposure to secondhand smoke and connect providers and parents to available community resources for smoking cessation.

Starting with 2010 births, Missouri will add smoking status by trimester as recommended by the National Center for Health Statistics. BHI will continue development on Web-based birth system to capture 'last trimester of pregnancy' and anticipates providing this data at a later date. Newborn Health will distribute Mom Don't Smoke and Dad Don't Smoke postcards to educate mothers and fathers on the dangers of tobacco use and second hand smoke during pregnancy and for their unborn child.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	6.9	7.9	5.9	5.3	8
Annual Indicator	9.9	6.5	8.5	8.5	11.6

Numerator	41	27	35	35	48
Denominator	414314	416034	412208	414182	414182
Data Source					MO DHSS. Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	9.5	9.5	9	9	8.5

Notes - 2008
Source: DHSS Vital Statistics. Numerator is provisional death number of persons age 15 through 19 years as of April, 2009. Final number will be available November, 2009. The 2007 population estimate of persons age 15-19 years is used as proxy for 2008. The 2008 population number will be available November, 2008.

The teen suicide death rate increased in 2008 compared with that in 2007. However, this increase was not statistically significant. The teen suicide deaths were geographically dispersed. A majority of the deaths were among ages18-19 years, males, and whites. About half of the deaths were by discharge of firearms.

Since 2004, there has been an ongoing controversy over whether antidepressant medications might reduce or increase suicide risk in children and adolescents. There is a wide range of factors that might lead to suicide. Considering the small number of deaths and possible fluctuation for one-year data, it is too early to say this is a start of a real increase. Objectives 2009-2013 were based on the three-year (2006-2008) average rate of 9.5 per 100,000 and discussions with the Section of Healthy Families and Youth, DHSS.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) Death,
and Bureau of Health Informatics, MO DHSS. 2007 provisional death data as of April 28, 2008. 2007 final death data will be available in November 2008. 2007 denominator of population estimate 15-19 years of age is not available yet, and 2006 population estimate is used as a proxy for 2007. 2007 population estimate for specific age groups will be available in November 2008.

Future objectives 2008-2012 were based on trend analysis on data 1999-2007 and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2006
2006 Missouri Information for Community Assessment (MICA) data was used for the numerator. A Census Bureau 2006 population estimate was used for the denominator.

2007-2011 annual performance objectives based on a logistic regression of 2001-2005 indicators.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

a. Last Year's Accomplishments
Unfortunately, MO experienced a rise in teen suicides in 2008. Analysis of the 48 teens involved found the majority to be 18-19 years of age, predominantly males, distributed throughout the

state, without any seasonal pattern, and the preferred method being firearm use. This information has been shared with the Department of Mental Health and the state Suicide Prevention Advisory Committee for their input.

Department of Mental Health has taken the lead on the Bright Futures state planning team, and with additional partners, is planning to pilot a public health model for mental health resiliency in communities with several schools. Work during this year involved revamping the planning team, bringing in new partners with funding to contribute to the project and educating all partners on the public health model. MCH program staff sits on the state planning committee.

CASH and partners continued to address the MISSOURI STATE FRAMEWORK FOR PROMOTING THE HEALTH OF ADOLESCENTS priority to promote developmentally appropriate physical and mental health strategies to meet the needs of adolescents.

The State Adolescent Health Coordinator represented DHSS on the Governor's Substance Abuse Prevention Initiative Advisory Committee that is addressing underage drinking and other alcohol-related problems. Substance abuse and other related mental health conditions are linked to suicide prevention. The Coordinator also serves on the MYAA against underage drinking.

Current Adolescent Health Issues and Trends training in collaboration with adolescent medical specialists and local co-sponsors were conducted at 7 locations. Physical and mental health care issues were addressed.

ADOLESCENT SHORTS newsletters published related articles including social networking safety; eating disorders; and alcohol energy drinks.

TOP contractors addressed bullying prevention in the after-school and service-learning clubs for youth.

MCH and School Health Programs with Heartland Centers at St. Louis University School of Public Health, UM, Center for the Advancement of Mental Health Practices in Schools, Missouri School Success Network, DMH, DSS, Early Childhood, School Boards Association and Head Start formed a collaboration to address shared responsibilities regarding children's mental health issues using BRIGHT FUTURES IN PRACTICE: MENTAL HEALTH as a framework to address mental health promotion, early identification of children with the potential for mental health issues and de-stigmatization of mental illness. Shared funding was identified and grant funding sought to pilot three school/community sites. This collaborative refined their infrastructure and will begin active work with communities next year.

Home Visiting programs continued to assess all women enrolled in the programs for post-partum depression using the Edinburgh Post partum depression screening tool. Approximately 50% of the women enrolled are teenagers.

TEL-LINK, DHSS's toll-free telephone line for maternal and child health care, provides information and referrals to Missourians concerning mental health services as requested.

BHI continued to provide the data needed to produce this measure. Teen suicide deaths are collected from the vital statistics system and the number of teens aged 15 to 19 are obtained through population estimates.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Adolescent Medicine Consultant provided training on mental health		X	X	

2. Regional Workshops promoted quality mental health care for adolescents		X	X	
3. ADOLESCENT SHORTS newsletter		X	X	
4. Statewide suicide prevention workshops for school staff conducted		X	X	X
5. MCH continues to address suicide prevention with some of those LPHAs contracts addressing intentional injury prevention			X	X
6. TEL-LINK provided information and referrals concerning mental health and crisis intervention			X	
7. BHI provided the teen suicide deaths come from the vital statistics system and the number of teens aged 15 to 19 comes from population estimates				X
8.				
9.				
10.				

b. Current Activities
MCH Coordinated Systems contracts with 40 LPHAs address injury prevention in MCH population with their community partners. Some are working with schools, businesses, health providers and faith community to address suicide prevention in adolescents. MCH District Nurse Consultant began serving on the mandated Missouri Suicide Prevention Advisory Committee and represents DHSS.

MCH Coordinated Systems, School Health Program, UM Center for Advancement of Mental Health Practices in Schools, DMH, Head Start, MSBA, Children's Trust Fund and DESE provide communities assistance to build capacity for mental health issues.

Home Visiting programs assess all women enrolled for post-partum depression using the Edinburgh Post partum depression screening tool. Approximately 50% are teenagers.

ADOLESCENT SHORTS provides best practices in caring for adolescents. Adolescent Medicine and Health Consultation contract with Children's Mercy Hospital offers adolescent health issues training.

SAHC serves on MYAA and represents DHSS on DMH-coordinated Governor's Substance Abuse Prevention Advisory Committee addressing risky drinking in 12-25 age group.

DHSS Adolescent Health Team and CASH address priorities related to this performance measure.

TOP contractors are addressing bullying prevention.

Adolescent Health and School Health Services participate in national initiative School Mental Health Capacity Building Partnership with HRSA and National Assembly on School-Based Health Care.

BHI provides data.

c. Plan for the Coming Year
TEL-LINK, DHSS's toll-free telephone line for maternal and child health care will provide information and referrals to Missourians concerning mental health services as requested.

The newsletter, ADOLESCENT SHORTS, will provide information on best practices in caring for

adolescents. Training on current adolescent health issues will be offered through the Adolescent Medicine and Health Consultation contract with Children's Mercy Hospital.

The SAHC will represent DHSS on the Governor's Substance Abuse Prevention Advisory Committee addressing risky drinking (binge and underage) in the age group of 12-25 and the MYAA against underage drinking. Substance abuse and other mental health conditions are linked to suicide prevention.

DHSS Adolescent Health Team and CASH will continue to promote developmentally appropriate physical and mental health services to meet the needs of adolescents as set forth in the State Framework for Adolescent Health.

School Health Program will train four school districts, provide information, support and consultation to other school districts and assist to develop funding strategies in OBPP. The program will continue to partner with DMH, DSS, and DESE to promote education sessions and awareness.

The School Health Program continues in a leadership role in the Missouri Bright Futures Initiative, a community based mental health prevention initiative involving public health, public education, mental health and community members. This year, three communities will attend a leadership academy whose goal is to promote a public health approach to mental health promotion at the community level.

The MCH Coordinated Systems contracts with LPHAs will be renewed with 1 MCH health issue addressed. Reducing Intentional and Unintentional Injuries the focus of some contracts with population-based services and community initiatives addressing injury prevention in the MCH population. Some contractors address suicide prevention in the adolescent population through collaboration with schools, businesses, health providers and the faith community. MCH Coordinated Systems staff will continue to provide consultation and technical assistance to LPHAs and local school health staff on suicide prevention in their communities. MCH program staff serves on the Bright Futures State Planning Team and will support the pilot Training Academies by providing reference manuals and DVDs.

MCH Coordinated Systems and the School Health Program continues to partner with the UM Center for the Advancement of Mental Health Practices in Schools, DMH, Head Start, DESE and the MO School Board Association, using the Bright Futures in Practice: Mental Health framework to provide technical assistance to communities wishing to build the capacity of their community to address mental health issues.

BHI will continue to provide the data needed to produce this measure from the vital statistics system the teen suicide deaths and from population estimates the number of teens aged 15 to 19.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	79.9	80.2	80.6	80.9	77
Annual Indicator	79.0	77.6	73.1	76.2	78.1
Numerator	886	880	825	893	854
Denominator	1122	1134	1128	1172	1093
Data Source					MO DHSS. Vital Statistics

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	78.5	79	79.5	80	80.5

Notes - 2008
Source: Missouri Information of Community Assessment (MICA). DHSS Vital Statistics. Denominator is very low birth weight (VLBW) infants born to Missouri residents and delivered in Missouri, provisional data as of April 2009. Numerator is VLBW infants delivered at Level III Missouri hospitals. Final numbers will be available November, 2009.

From 1990 to 2005, the percent of VLBW infants delivered at level III hospitals had fluctuated around 78%. There was a noticeable decrease from 77.6% in 2005 to 73.1% in 2006 (p=0.01), but the decrease did not continue in 2007. MO had seen an increase for two consecutive years 2007-2008. Several complex issues might limit improvement in this measure, including inappropriate admission based on insurance status or due to competitive admission among hospitals, and increase in Newborn Intensive Care Unit beds in both level II and III hospitals over years.

An annual increase of about 0.5% was set to create objectives for 2009-2013, based on data in the last 3 years, long-term trend in the past 10 years and discussions with the Bureau of Health Informatics and the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
Source: Bureau of Health Informatics, DHSS. Birth Data. Denominator is the number of VLBW infants to Missouri residents delivered in Missouri; numerator is the number of VLBW infants to Missouri residents delivered in Level III hospitals in Missouri. 2007 birth data are provisional, and 2007 final birth data will be available in October 2008.

An annual increase of about 1% was set to create future objectives for 2008-2012, based on discussions with the Bureau of Health Informatics and the Section of Healthy Families and Youth, MO DHSS.

Notes - 2006
Data source is Missouri Information for Community Assessment (MICA).

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

a. Last Year's Accomplishments
Home Visiting and Alternative to Abortion program contractors educated women on the need for: early entry into prenatal care, adequate prenatal care and choosing an appropriate prenatal care provider. Educational materials on preconceptual care to decrease the incidence of pre-term visits are available on the DHSS Web site through the Newborn Health program.

The Missouri Model for Brief Smoking Cessation Training (MO Model) was offered in 2008 through a $18,100 March of Dimes grant awarded to ATODPA. The MO Model is an educational outreach to health care clinicians in support of comprehensive tobacco control program with women of reproductive age, particularly pregnant women. DHSS facilitated MO Model development in 2005 and its implementation in 2006, 2007 and 2008. Developed and presented

by a research psychologist associated with UMC, the MO Model is based on the U.S. Public Health Services' five-step intervention (5 As) outlined in the CLINICAL PRACTICE GUIDELINE: TREATING TOBACCO USE AND DEPENDENCE and adopted by American College of Obstetricians and Gynecologists (ACOG). The MO Model also incorporates transtheoretical model on stages of change; motivational interviewing; current cessation pharmacotherapy; Missouri Tobacco Quitline for tobacco cessation and prevention of relapse; and techniques integrating proven cessation strategies into clinical setting. QuitLine (800-QUIT-NOW) is a free service and provides smoking cessation coaching, self-help materials and optional registration to a free supplemental online Web Coach.

Five MO Model trainings, consisting of one to two-hour trainings targeting physicians and healthcare providers were provided to 130 individuals through five medically-related societies (i.e. dental, dental hygienist, medical, and respiratory therapists). The one to two-hour trainings were offered with established groupings of physicians, two medical societies, one dental society, one dental hygienist society and a respiratory therapist society at their annual conference. Pre-and post-training surveys and follow-up surveys of MO Model participants showed significant differences in knowledge and behavior change in terms of smoking cessation discussions with women and use of resources.

Missouri Tobacco Quitline is a free service, available at 800-QUIT-NOW; provides smoking cessation coaching, self-help materials and optional registration to a free supplemental online Web Coach; and is one of the resources highlighted in MO Model training.

Also "Evidence-Based Interventions to Help Women Quit Smoking", regarding smoking cessation techniques and highlighting the Missouri Tobacco Quitline, was presented at the 2007 Missouri Section ACOG meeting and was well received by the physicians in attendance.

TEL-LINK, DHSS's toll-free telephone line (1-800-TEL-LINK) for maternal and child health care connected callers to various services, including pediatric and delivering hospitals, alcohol and drug abuse treatment centers, community health centers, crisis pregnancy centers, local health departments, mental health centers and prenatal clinics. Radio advertisement of the toll-free number was promoted in St. Louis on the importance of early and regular prenatal care. Collaboration with other state programs regarding breastfeeding and prenatal birth defects was promoted. TEL-LINK collaborated with "Missouri's Think Before You Drink Campaign" which encouraged women to call TEL-LINK for free educational materials on women's health and alcohol. The campaign was promoted through Facebook, an Internet social network.

BHI provided the data needed to produce this measure. Birth weight and place of birth are collected through the vital statistics system. Level of care data is collected through the Annual Hospital Licensing Survey of Missouri Hospitals.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Home Visiting programs educated clients on need for early entry into and adequate prenatal car		X		
2. Education about the impact of alcohol, tobacco and other drug exposure on pregnancy and interventions to assist in cessation efforts were provided to health care professionals working with women of reproductive age		X	X	
3. Genetic tertiary centers provided genetic screening, counseling, medical referral and outreach		X	X	
4. TEL-LINK connected callers to LPHAs, prenatal clinics, pediatric and delivering hospitals			X	X
5. BHI continues to provide the data needed to produce this				X

measure. Birth weight and place of birth are collected through the vital statistics system. Level of care data is collected through the Annual Hospital Licensing Survey of Missouri Hospitals				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Home Visiting and Alternatives to Abortion educate clients on need for preconceptual care, early entry into and adequate prenatal care and effects of alcohol, tobacco and other drugs; provide smoking cessation referrals to mothers wishing to quit smoking and referrals to CSTAR to mothers using alcohol or other drugs; and assess clients for domestic violence.

In July 2009 the Alternatives to Abortion program will begin collecting data on all women who enroll in the program on the gestational age of the woman when she began prenatal care when she enrolls.

Self-help materials on smoking cessation and educational brochures in English, Spanish, Vietnamese and Chinese are available for health care providers and Missouri families.

TEL-LINK provides information and referrals on pregnancy testing and prenatal care. TEL-LINK targeted the Hispanic population through advertisements in two bilingual newspapers known as DOS MUNDOS and the KANSAS CITY HISPANIC NEWS. Advertisement of the toll-free number continued in St. Louis on busboards and interior cards on the MetroLink.

BHI provided the data needed to produce this measure.

c. Plan for the Coming Year

TEL-LINK, DHSS's toll-free telephone line for maternal and child health care, will provide information and referrals to females regarding pregnancy testing and prenatal care.

Home Visiting and Alternatives to Abortion programs will continue to educate clients on the need for early entry and adequate prenatal care; educate clients on the effects of alcohol, tobacco and other drugs; provide smoking cessation referrals to all mothers who wish to quit smoking; refer mothers who are using alcohol or other drugs to CSTAR programs; and assess clients for domestic violence. Alternatives to Abortion providers will continue to collect data on when women who enroll in their program entered prenatal care. This data is also collected by the two home visiting programs.

BHI will continue to provide birth weight and place of birth from the vital statistics system and level of care data from the Annual Hospital Licensing Survey.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	86.6	86.8	87	87.3	84.6
Annual Indicator	86.2	86.0	84.7	84.1	83.8

Numerator	66980	67571	68919	68863	67788
Denominator	77709	78547	81353	81883	80868
Data Source					MO DHSS. Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	84	84.2	84.4	84.6	84.8

Notes - 2008
Source: Missouri Information for Community Assessment (MICA)-Births. DHSS Vital Statistics. Provisional 2008 data as of April, 2009. Final data will be available, November, 2009.

The proportion of early prenatal care in Missouri has been consistently above the national level. Since 2006, the percentage in Missouri had shown a small but noticeable decline and the decline had continued for three consecutive years 2006-08. The decline was slightly larger in Medicaid population than in non-Medicaid population. A similar decline had been observed in the national data in 2005 and 2006.

More recent changes to welfare and Medicaid policy might limit further improvements in timely care. Some MO hospitals have shifted from using self-reported information by the mother to using electronic medical records to collect prenatal care information for the birth certificate. It was reported that there had been a decline in early prenatal care following the implementation of a revised birth certificate that uses electronic prenatal care records.

An annual increase of 0.2% is used to create objectives 2009-2013, based on general increasing trend 1990-2008 and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Birth,
and Bureau of Health Informatics, MO DHSS. 2007provisional data as of April 28, 2008. 2007 final birth data will be available in October 2008.

There has been a slight decrease in the percent of prenatal care in the 1st trimester since 2006. It has been not clear why the number goes down. Some potential factors are speculated such as limited access to care and capacity of delivering doctors, and changes in prenatal care data collection from using self-reported information by the mother to using electronic medical records. An annual increase of 0.5% is used to create objectives 2008-2012, based on discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2006
Data source is Missouri Information for Community Assessment (MICA).

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

a. Last Year's Accomplishments
MCH Coordinated Systems continued to use Title V funds to support community-based interventions through contracts with 13 LPHAs to increase the percent of women who enter prenatal care during the first trimester.

OPCRH continued to support the expansion of services and sites of FQHCs, to assure access to essential, primary and preventive medical, dental and mental health services for all MCH populations, without regard to individual's ability to pay. With the support of OPCRH, at least three dental clinics were established in 2007-2008 or are being established with additional FQHCs requesting support. This will have a definite impact on improving access to dental care. OHP continues to support expansion of services and sites of FQHCs to improve access of care. There are 21 FQHCs in Missouri with 40 delivery sites. All FQHCs have dental clinics except one and that dental clinic will be opening in the next 90 days. OHP in conjunction with Head Start, MPCA and Maternal Child Health Bureau presented Infant Oral Care Training to oral health professionals and medical teams including physicians, nurse practitioners, physician assistants. The trainings emphasized the important role that oral health plays in overall health and birth outcomes and was very well received. OHP expanded educational efforts with the WIC and MCH units of DHSS to expand and enhance oral health education activities. In order to implement the Oral Health PSP throughout Head Starts in Missouri, OHP continued to partner with FQHCs to further assist in developing community support for the PSP. The OHP continues to collaborate with FQHCs to assist in developing community support for PSP. In addition, OHP in collaboration with the PRIMO program has entered into a contractual agreement with New Madrid County Health Center to work with community dentists to ensure a referral network for urgent care and other oral health care needs identified through the PSP.
The MCH population benefited by receiving home visits by registered nurses (Building Blocks and MCBHV) and lay family support workers (MCBHV) who provided: assessment, education, case management, referrals for services, influence on mother's life course development by continuing education and attaining employment, help to improve relationships with family and friends, development of parenting skills, help to improve environmental health, help to improve health of the mother and identified and interacted in situations of domestic violence and child abuse and neglect.

The MCH population benefited by receiving home visits by registered nurses (Building Blocks and MCBHV) and lay family support workers (MCBHV) who provided: assessment, education, case management, referrals for services, influence on mother's life course development by continuing education and attaining employment, help to improve relationships with family and friends, development of parenting skills, help to improve environmental health, help to improve health of the mother and identified and interacted in situations of domestic violence and child abuse and neglect.

TEL-LINK, DHSS's toll-free telephone line (1-800-TEL-LINK) for maternal, child and family health services, provided information and referrals health services including pregnancy testing and prenatal care. Radio advertisement of the toll-free number was promoted in St. Louis on the importance of early and regular prenatal care. Collaboration with other state programs regarding breastfeeding and prenatal birth defects was promoted. TEL-LINK collaborated with "Missouri's Think Before You Drink Campaign" which encouraged women to call TEL-LINK for free educational materials on women's health and alcohol. The campaign was promoted through Facebook, an Internet social network.

BHI provided the data needed to produce this measure from the vital statistics system.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH coordinated systems provided technical support and consultation to LPHAs who wished to address early entry into prenatal care within their communities in addition to their selected health issue focus			X	X
2. OPCRH continued to support the expansion of services and				X

sites of FQHCs, to assure access to essential, primary and preventive medical, dental and mental health services for all MCH populations				
3. Home Visiting programs implemented included Building Blocks of Missouri in Kansas City, Southeast Missouri and St. Louis. MCBHV was implemented in sites targeting high-risk women and promoting the need for early prenatal care		X		
4. Newborn Health and Baby Your Baby Web site provided education promoting prenatal care			X	
5. TEL-LINK referrals for pregnancy testing and prenatal care			X	X
6. BHI provided this data from the vital statistic system				X
7.				
8.				
9.				
10.				

b. Current Activities
MCH Coordinated Systems contracts were renewed with three focus area of injury, obesity and tobacco prevention. MCH staff continue to offer consultation and technical support to LPHAs addressing adequate prenatal care.

Both Home Visiting and Alternatives to Abortion programs educate mothers on the need for prenatal care and the importance of early entry into prenatal care, as well as preconceptual care.

In July 2009, Alternatives to Abortion program will begin collecting data on all women who enroll in the program on gestational age when they entered prenatal care when they enroll.

The Baby Your Baby Web site (www.dhss.mo.gov/babyyourbaby) continues to provide information for pregnant women, their families and communities on healthy pregnancies and healthy babies. The site includes a wide range of topics including prenatal care, breastfeeding, immunizations, well child checkups and special health care needs.

TEL-LINK, DHSS's toll-free telephone line(1-800-TEL-LINK) for MCH services, provided information and referrals health services including pregnancy testing and prenatal care. Radio ad of TEL-LINK in St. Louis promoted the importance of early/regular prenatal care, breastfeeding and prenatal birth defects. TEL-LINK collaborated to provide free educational materials on women's health and alcohol. Promoted through Facebook.

BHI continues to provide this data from the vital statistics system.

c. Plan for the Coming Year
Alternatives to Abortion programs will continue to educate mothers on the need for prenatal care and the importance of early entry into prenatal care. They assist mothers in finding a prenatal care provider. Alternatives to Abortion providers will continue collecting data on when women who enroll in their program entered prenatal care. This data will be collected by the two home visiting programs.

Baby Your Baby web site (www.dhss.mo.gov/babyyourbaby) will continue to provide information for pregnant women, their families and communities on healthy pregnancies and healthy babies. The site includes a wide range of topics including prenatal care, breastfeeding, immunizations, well child checkups and special health care needs. This Web site will remain active through January 2013.

DHSS sponsored Home Visiting programs will continue to encourage early entry into prenatal

care and also provides in home education for pregnant mothers. Data will be collected on entry into prenatal care.
MCH Coordinated Systems will continue to offer consultation and technical support to LPHAs addressing adequate prenatal care. Best practice interventions and research information related to assuring appropriate prenatal care and linking families to local resources will be shared with partners as needed.

OMH will conduct a social marketing campaign in selected zip code areas of St. Louis and will educate health professionals and nursing staff about resources and services available to prenatal and postnatal women. Education will be provided to parents of infants born within the targeted area.

BHI will continue to provide this data from the vital statistics system.

D. State Performance Measures

State Performance Measure 1: *Percent of women who have reported smoking during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	17.7	17.5	16.3	14.4	16.5
Annual Indicator	18.1	18.2	18.4	17.7	17.6
Numerator	14083	14317	14946	14534	14201
Denominator	77709	78547	81353	81883	80868
Data Source					MO DHSS. Vital Statistics
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	17.3	17.1	17	16.8	16.7

Notes - 2008
Source: Missouri Information for Community Assessment (MICA)-Births. DHSS Vital Statistics. Provisional 2008 live births number as of April, 2009. Final data will be available, November, 2009.

Since 2007 MO had seen a small but continuing decrease in maternal smoking for two consecutive years 2007-2008. Objectives 2009-2013 were based on trend analysis on data 1994-2008, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA)- Births
and the Bureau of Health Informatics, MO DHSS. 2007provisional data as of April 28, 2008. 2007 final birth data will be available in October 2008.

Despite limited funding for tobacco prevention and cessation programs in Missouri, we intend to make every effort to make progress in this measure. Objectives 2008-2012 were set with considerations of trend analysis on data 1990-2007, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2006

Data obtained from birth certificate records reported in MICA (Missouri Information for Community Assessment). 2005 numbers used, 2006 data not yet available as of July 2, 2007.

Annual performance objectives for 2007-2011 are based on a regression analysis of the maternal smoking during pregnancy trend in Missouri during 1999-2005.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

a. Last Year's Accomplishments

MCH Coordinated Systems renewed contracts with LPHAs to focus on one of the three issues of injury, obesity and tobacco prevention among adolescents and women. 24 LPHA addressed this issue with MCH funding. Additional LPHAs addressed the smoking issue with other funding. Each has contractual obligation to utilize evidence-based interventions. Local systems development with community partners was the primary focus with planning for interventions and environmental and policy changes to impact these issues. A two day state-wide training, 2008 MCH Institute, provided sessions to 253 attendees on Missouri best-practices and working with community partners.

OWH developed a Tobacco Cessation fact sheet for distribution and posted on OWH Web site.

Home Visiting programs continued training of home visitors in promoting smoking cessation and referring clients to Quitline.

Baby Your Baby Web Site, www.dhss.mo.gov/babyyourbaby, covered topics including smoking cessation during pregnancy.

Newborn Health educational material in English and Spanish was distributed to service providers and families to promote smoking cessation during pregnancy.

The Missouri Model for Brief Smoking Cessation Training (MO Model) was offered in 2008 through a $18,100 March of Dimes grant awarded to ATODPA. The MO Model is an educational outreach to health care clinicians in support of comprehensive tobacco control program with women of reproductive age, particularly pregnant women. DHSS facilitated MO Model development in 2005 and its implementation in 2006, 2007 and 2008. Developed and presented by a research psychologist associated with UMC, the MO Model is based on the U.S. Public Health Services' five-step intervention (5 As) outlined in the CLINICAL PRACTICE GUIDELINE: TREATING TOBACCO USE AND DEPENDENCE and adopted by American College of Obstetricians and Gynecologists (ACOG). The MO Model also incorporates transtheoretical model on stages of change; motivational interviewing; current cessation pharmacotherapy; Missouri Tobacco Quitline for tobacco cessation and prevention of relapse; and techniques integrating proven cessation strategies into clinical setting. QuitLine (800-QUIT-NOW) is a free service and provides smoking cessation coaching, self-help materials and optional registration to a free supplemental online Web Coach.

Five MO Model trainings, consisting of one to two-hour trainings targeting physicians and healthcare providers were provided to 130 individuals through five medically-related societies (i.e. dental, dental hygienist, medical, and respiratory therapists). The one to two-hour trainings were offered with established groupings of physicians: two medical societies, one dental society, one dental hygienist society and a respiratory therapist society at their annual conference. Pre-and post-training surveys and follow-up surveys of MO Model participants showed significant differences in knowledge and behavior change in terms of smoking cessation discussions with women and use of resources.

In addition to the MO Model trainings, a presentation regarding smoking cessation techniques and highlighting the Missouri Tobacco Quitline was made at the 2007 Missouri Section ACOG

meeting. The topic "Evidence-Based Interventions to Help Women Quit Smoking" was well received by the 33 physicians in attendance.

CCHCs provided group education to child care providers on the risks of smoking and secondhand smoke.

BHI provided data from vital statistics system.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH Coordinated Systems 3-year contracts with 24 LPHAs to support community-based interventions to reduce percent of women who smoke during pregnancy through infrastructure development, community interventions and direct services to pregnant women		X	X	X
2. OWH developed a Tobacco Cessation fact sheet for distribution and posted on OWH Web site			X	X
3. Home Visiting programs improved pregnancy outcomes by helping women practice healthy behaviors including decreasing the use of cigarettes, alcohol and illegal drugs		X		
4. Baby Your Baby Web site included helpful information on various healthy pregnancy and healthy baby topics			X	X
5. Newborn Health literature addressed decreasing smoking while pregnant			X	
6. Education about the impact of alcohol, tobacco and other drug exposure on pregnancy to health care providers practicing with at-risk populations		X		
7. Continued coordinated efforts to address smoking in women of reproductive age		X	X	
8. CCHCs provided consultation/education on smoking and secondhand smoke and cardiovascular disease prevention		X		
9. BHI provided this data from the vital statistic system				X
10.				

b. Current Activities

MCH Coordinated Systems contracts with 24 LPHAs to prevent tobacco use among adolescents and women. Each has contractual obligation to use evidence-based interventions to reduce smoking during pregnancy and to build a system within their community. LPHAs and their community tobacco coalitions are promoting healthy lifestyle choices and outreach/education to local health care providers and best practice methods. Regional trainings held.

Home Visiting and Alternatives to Abortion train home visitors to promote smoking cessation and refer clients to Quitline.

In 2009 Mo Model Trainings will be provided as requested using MCHBG funds.

BHI continued to develop a Web-based birth system to capture "last trimester of pregnancy". It is anticipated this data will be collected in 2010 and will be available for analysis at a later date.

MO Model participants are advised of new Quitline service: 4 weeks of NRT patches or gum at no cost to callers on Medicaid or have no insurance; NRT gum at no cost to pregnant women with physician approval.

Self-help materials on smoking cessation and educational brochures are in English, Spanish, Vietnamese and Chinese.

A contract deliverable for schools in School Health Services Program is active SHAC with community representation and at least one LPHA member to provide LPHA opportunity to promote public health activities.

CCHCs provide group education on smoking, secondhand smoke and cardiovascular disease prevention.

BHI continues to provide data.

c. Plan for the Coming Year

Alternatives to Abortion programs will continue to assess all women enrolled for smoking and educate mothers on the dangers of smoking during pregnancy including the dangers of secondhand smoke and effects on their infant and will work with the women to decrease the number who smoke by referring women to the state's Quitline and enrolling in smoking cessation programs.

Mo Model for Brief Smoking Cessation training will be made available to healthcare providers who request it through MCH Block Grant funds.

Missouri Tobacco Quitline is a free service, available at 800-QUIT-NOW, which provides tobacco use cessation coaching, self-help materials, nicotine patches or gum for eligible callers, optional registration to a free supplemental online Web Coach and expert consultation to health care providers with clinical questions.

Self-help materials on smoking cessation and brochures in English, Spanish, Vietnamese and Chinese addressing tobacco use in pregnant women will be available for use by health care providers and Missouri families.

DHSS-sponsored Home Visiting programs will continue to screen all pregnant women for tobacco use and refer to the Quitline as needed. Education is done on the dangers of smoking and secondhand smoke. The programs collect data on the smoking habits of women enrolled in the programs and are able to evaluate that data to look at program effectiveness.

The MCH Coordinated Systems three-year contracts with LPHAs will be renewed with one focus area being preventing tobacco use among adolescents and women. Each contractor will have a contractual obligation to utilize evidence-based interventions. Local system development to address smoking prevention and cessation will include direct smoking cessation interventions, community-based interventions and environmental and policy changes to impact the initiation of smoking in this population. Contractors will also be evaluating their efforts to address this issue.

CCHCs offer education to child care providers and young parents regarding the risks of smoking and exposure to secondhand smoke. CCHCs will connect providers and parents to available community resources for smoking cessation.

BHI will continue to provide this data from the vital statistics system.

Newborn Health will continue to distribute Mom Don't Smoke and Dad Don't Smoke postcards to education mothers and fathers on the dangers of tobacco use and second hand smoke during pregnancy and for their unborn child.

State Performance Measure 2: *Percent of cigarette smoking among children 14-18 years of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	30.5	30	19.4	17.4	23.3
Annual Indicator	24.8	21.3	21.3	23.8	23.8
Numerator	62425	59081	60210	68127	67789
Denominator	251713	277374	282678	286247	284830
Data Source					Missouri Youth Risk Behavioral Survey
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	22.8	22.3	21.8	21.3	20.8

Notes - 2008
Source: Annual indicator is percentage from 2007 CDC's Youth Risk Behavioral Survey "Percentage of high school students who smoked cigarettes on one or more of the past 30 days. Numerator is based on percentage. Denominator is estimate using number of fall enrollment grades 9-12 for school year 2007-2008 obtained from the MO Dept. of Elementary & Secondary Education.
YRBS survey is conducted every 2 years. Next survey results will be available summer 2010.

Objectives for 2009-2013 were set with considerations of trend analysis on MO YRBS data 1995-2007, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
The annual indicator is from the 2007 YRBS statistic "Percentage of high school students who smoked cigarettes on one or more of the past 30 days". The denominator is estimated using the number of fall enrollment, grades 9-12 for school year 2006-2007, obtained from the the MO Department of Elementary and Secondary Education.

Objectives for 2008-2012 were set with considerations of trend analysis on MO YRBS data 1995-2007, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2006
YRBS not conducted during 2006. 2005 data is used as a proxy for 2006 since the YRBS is reported every two years. 2007 data available next year.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

a. Last Year's Accomplishments
MCH Coordinated Systems continued to use Title V funds to support community-based interventions through LPHAs to reduce teen tobacco use by involving collaborative efforts with school and community partners to implement best practice interventions which promote healthy lifestyle choices.

CCHCs provided group education to young adults and school age children on the dangers smoking and secondhand smoke.

BHI provided this data from the YRBS system and the YRBS MICA.

The YRBS was completed in June 2007.

The Youth Tobacco Survey was conducted in 2007. The analysis was completed in 2008; the Tobacco Use by Missouri Youth Fact Sheet was updated and posted on the DHSS web.

Various DHSS programs explored ways to integrate evidence-based tobacco use prevention strategies, including youth development and advocacy, with other related adolescent health concerns into Teen Outreach Programs, contracts with schools and local public health agencies. Smokebusters and Teens Against Tobacco programs were presented at the MCH Institute as models for partnering with teens to promote health.

97 schools, 1,037 youth, and 127 adult mentors (leaders) participated in Smokebusters. The Smokebusters youth educated 18,209 children and 34,271 adults in their communities regarding tobacco issues.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Use of tobacco in public high schools was monitored through YRBS, DHSS Youth Tobacco Survey; biennial alcohol, tobacco and other drug use survey by DMH and DESE			X	
2. CDC School Health Index used to assess school policies and practices for tobacco-use prevention		X	X	X
3. MCH Coordinated Systems 3-year contracts renewed with 24 LPHAs developing local systems to support community-based interventions to reduce adolescent smoking		X	X	X
4. CCHCs provided group education to young adults and school-age children on the dangers smoking and secondhand smoke		X	X	
5. BHI provided this data from the YRBS system and the YRBS MICA				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH Coordinated Systems contracts with 24 LPHAs to prevent tobacco use among adolescents and women. Each contractor has a contractual obligation to utilize evidence-based interventions to address the issue of smoking in their community. System development to address smoking prevention and cessation include direct smoking cessation interventions, community-based interventions and environmental and policy changes to impact the initiation of smoking in this population. Many community-based interventions focus on youth tobacco prevention in schools using best practice interventions to promote healthy lifestyle choices, decision-making, general tobacco prevention educational campaigns and advocating for policy changes with community assessment and policy recommendations to local school boards and businesses. Smoke Busters programs are being implemented in schools with several becoming smoke-free campuses.

During the 2008 legislative session, $1.7 was appropriated to DHSS for youth tobacco prevention

programs. Approximately 160 schools are implementing programs based on CDC Best Practices for Comprehensive Tobacco Control Programs during the 2008-09 school year.

In 2009, the first Show-Me Smoke-Free Youth Summit was held at the State Capitol; 400 youth and 200 adults from 64 schools attended to learn new skills in tobacco control.

DHSS Adolescent Health Team and CASH address priorities related to this performance measure.

BHI continues to provide links to this data in the YRBS system.

c. Plan for the Coming Year

Adolescent Health Program will work with BHP on state-funded youth tobacco initiative and strategies to partner with youth to develop and implement tobacco use prevention campaigns, programs and policies. Collaboratively continue and expand youth tobacco prevention programs across the state.

DHSS Adolescent Health Team and CASH will address adolescent health system capacity priorities related to this performance measure.

The school health contractors are implementing action plans based upon the School Health Index Assessment of policies and practices. 27 school districts have action plans related to tobacco use prevention.

The MCH Coordinated Systems three-year contracts with LPHAs will be renewed with one of the focus areas as preventing tobacco use among adolescents and women. Each contractor has a contractual obligation to utilize evidence-based interventions to address the issue of smoking in their community. Local system development to address smoking prevention and cessation will include direct smoking cessation interventions, community-based interventions and environmental and policy changes to impact the initiation of smoking in this population. Many community-based interventions will be focused on youth tobacco prevention in schools using best practice interventions to promote healthy lifestyle choices, decision-making, general tobacco prevention educational campaigns and advocating for policy changes with community assessment and policy recommendations to local school boards and businesses. LPHAs will be evaluating efforts within their communities to address this issue.

CCHCs will offer health promotion education to children in child care (up to 12 yrs) on the risks of smoking and exposure to secondhand smoke.

BHI will continue to provide this data from the YRBS system and the YRBS MICA.

State Performance Measure 3: *Percent of mothers who are prepregnancy overweight by 20% or more.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			35.2	34.7	36.8
Annual Indicator	36.2	36.5	36.7	36.9	37.5
Numerator	28155	28637	29832	30220	30322
Denominator	77709	78547	81353	81883	80868

Data Source					MO DHSS. Vital Statistics
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	37.4	37.3	37.2	37.1	37

Notes - 2008
Source: Missouri Information for Community Assessment (MICA)-Births. DHSS Vital Statistics. Provisional 2008 live births number as of April, 2009. Final data will be available, November, 2009.

The steady increasing trend in prepregnancy overweight in MO mirrors the secular trend in overweight and obesity among general women population in both MO and the U.S. Reducing obesity is a priority of the state. We intend to make every effort to make progress in this measure. An annual decrease of 0.1% was set to create objectives 2009-2013.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Birth
and Bureau of Health Informatics, MO DHSS. 2007provisional data as of April 28, 2008. 2007 final birth data will be available in October 2008.

The trend analysis on data 1990-2007 shows the increasing trend in prepregnancy overweight in Missouri has tended to slowdown since 2004 but not yet revsersed. A slight decrease from the current level would be an improvement. An annual decrease of 0.1% was set to create future objectives 2008-2012.

Notes - 2006
2005 numbers used, data not available for 2006 as of July 2, 2007. Data obtained from birth certificate records reported in MICA (Missouri Information for Community Assessment).

Annual performance objectives for 2007-2011 are based on a regression analysis of data from 1990-2004.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

a. Last Year's Accomplishments
Home Visiting programs continued data collection and worked with mothers on diet counseling and nutrition.

Evaluation of the PAMR data continued to obtain a better understanding of the problem and the ability to develop interventions.

CCHCs provided 302 hours of nutrition education and 107 hours of education on the importance of physical activity to child care providers.

The MCH Coordinated Systems 3-year contracts with LPHAs were renewed to address one of three MCH health issues; injury, obesity and tobacco prevention. Reducing obesity in the MCH population was the focus of 49 contracts with infrastructure building, population-based services and community capacity initiatives addressing obesity on the local level. Promising practices or research-based approaches included interventions that involve policy changes related to physical activity at local businesses or increased access to physical activity programs and resources within the community. Some rural contractors addressed the availability of wholesome and nutritious foods in their communities.

BHI provided data needed to produce this measure from the vital statistics system.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Home Visiting staff in the MCBHV and Building Blocks Programs collected weight gain on all women during pregnancy		X		
2. Evaluation of the Pregnancy Associated Mortality Review (PAMR) data continued			X	X
3. Child Care Health Consultants provided Nutrition and physical activity education to child care providers			X	
4. BHI provided data needed to produce this measure from the vital statistics system				X
5. MCH Coordinated Systems program renewed contracts with 49 LPHAs addressing obesity prevention with their community partners		X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH Coordinated Systems contracts with 49 LPHAs are addressing obesity prevention. Promising practices or research-based approaches including interventions that involve policy changes related to physical activity at local businesses or increased access to physical activity programs and availability of wholesome and nutritious food within the community are being implemented. Several communities are partnering with University Extension and planting community gardens in both rural and urban areas. Participants learn not only how to grow nutritious food, but how to prepare them.

Home Visiting programs continue data collection and work with mothers on diet counseling and nutrition.

CCHCs provide group education on nutrition and physical activity to child care providers.

BHI continues to provide data from the vital statistics system. Currently, BHI provides the value for pre-pregnancy weight and will do so for next year. Starting with 2010 births, Missouri will add mother's weight at birth of her child. These data will be available for analysis at a future date.

c. Plan for the Coming Year

Alternatives to Abortion programs will continue to be encouraged to refer overweight women to WIC and their physician for diet counseling.

DHSS-sponsored Home Visiting programs will continue to encourage pregnant women to utilize WIC and seek diet counseling.

The MCH Coordinated Systems three-year contracts with LPHAs will address one of three MCH health issues. Reducing obesity in the MCH population is the focus of some contracts with infrastructure building, population-based services and community capacity initiatives addressing

obesity on the local level. Promising practices or research-based approaches may include interventions that involve policy changes related to physical activity at local businesses or increased access to physical activity programs and resources within the community. Some rural contractors are addressing the availability of wholesome and nutritious foods in their communities.
LPHAs will be evaluating efforts with their community partners to address this issue.

BHI will continue to provide data from the vital statistics system. Currently, BHI provides the value for pre-pregnancy weight and will do so for next year. BHI will continue development on a Web-based birth system that will capture mother's weight at birth of her child starting with 2010 births. Data will be available for analysis at a later date.

State Performance Measure 4: *Percent of high school students who met currently recommended levels of physical activity.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			71.2	72.8	44.5
Annual Indicator	66.6	36.0	36.0	43.5	43.5
Numerator	167641	99854	101764	124517	123901
Denominator	251713	277374	282678	286247	284830
Data Source					Missouri Youth Risk Behavioral Survey
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	45.5	46.5	47.5	48.5	49.5

Notes - 2008
Source: Youth Risk Behavioral Survey (YRBS) 2007
A response of 5 or more days to the survey item "During the past 7 days, on how many days were you physically active for a total of at least 60 minutes per day?" (Add up all the time you spend on any kind of physical activity that increases your heart rate and makes you breathe hard part of the time). The 2007 YRBS estimate is being used as a proxy for 2008 obtained from the Mo Dept of Elementary and Secondary Education. Denominator is the number of enrollment of grades 9-12 during the 2007-2008 school year.
YRBS survey is conducted every 2 years. Next survey results will be available summer 2010.

An annual increase of 1% on this measure was chosen to create objectives for 2009-2013, based on estimates of the indicator in 2005 and 2007, comparisons with other states, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
The question used to estimate the indicator SPM # 4 "percent of students who participated in vigorous physical activity" was discontinued in the 2007 YRBS questionnaire: "On how many of the past 7 days did you exercise or participate in physical activity for at least 20 minutes that made you sweat and breathe hard ?". Instead, to reflect the current physical activity recommendation for youth, defined as "participation in any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes/day on >=5 of the 7 days preceding the survey", a new question has been added to

YRBS since the 2005 survey: "During the past 7 days, on how many days were you physically active for a total of at least 60 minutes per day? (Add up all the time you spend in any kind of physical activity that increases your heart rate and makes you breathe hard some of the time.)"

2007 YRBS estimate was obtained from the Missouri Department of Elementary and Secondary Education. The 2007 data was based on the new indicator "percent of students who were physically active for a total of at least 60 minutes per day on >=5 of the past 7 days". The data reported for 2007 is comparable with the data for 2005 but not comparable with data before 2005, which reflect previously recommended physical activity for youth. Denominator is number of fall enrollment of grades 9-12 during school year 2006-2007 from the Missouri Department of Elementary and Secondary Education.

YRBS data for the new indicator were only available for two years 2005 and 2007, which prevented the ability to conduct trend analyses. An annual increase of 1% on the new indicator was chosen to create future objectives for 2008-2012, based on estimates of the new indicator in 2005 and 2007, comparisons with other states, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2006
Data is an estimate based on results from the YRBS statistic "Percentage of students who exercised or participated in physical activity that made them sweat and breathe hard for 20 minutes or more on three or more of the past seven days" and the summary of Fall enrollment, grades 9-12, during 2004-05 and 2002-03 from the Department of Elementary and Secondary Education.

YRBS survey not conducted in 2006. Since YRBS is conducted every two years, 2005 data is used as a proxy for 2006. 2007 YRBS numbers unavailable until next year.

Annual performance objectives for 2007-2011 are based on a regression analysis of YRBS data from Missouri during 1995-2005.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

UPDATED field note as of May 2008:
2005 YRBS data is used as a proxy for 2006. 2005 numbers are revised based on a newly added question in the 2005 YRBS survey to reflect the currently recommneded physical activity for youth: "participation in any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes/day on >=5 of the 7 days preceding the survey". Therefore, data reported in 2005 and later are not comparable with data before 2005.

a. Last Year's Accomplishments
CASH and the AHP in collaboration with MoCAN consulted on the development of the physical activity and nutrition campaign targeted to young adolescents. CASH selected this campaign as a 2008-09 priority.

CASH and Coordinated School Health Coalition members made recommendations for integrating the eight components of the coordinated school health model in future Missouri School Improvement Program accreditation standards.

AHP and adolescent medical consultants presented sessions on "healthy habits for teens: nutrition and physical activity" at the regional Current Adolescent Health Issues trainings. Copies of the Child and Adolescent Healthcare Provider Tool Kit were distributed.

2008 MCH Institute showcased best practices in promoting physical activity and nutrition and

successful strategies for engaging youth.

The School Health Program partnered with Action for Healthy Kids, the Missouri Coordinated School Health Coalition and UM Extension Service to produce and disseminate to all public and private schools in Missouri an Interactive DVD, "Movin and Grovin" for teachers to use to foster 10 minutes of physical activity in the classroom. The Action for Healthy Kids Website as well as the Alliance for a Healthier Generation Website and model policies are featured at school health meetings and posted to list serves.

The School Health Program partnered with UM Extension to develop a model walking program for staff and students. The program and handouts are available on the School Health Web site.

The MCH Coordinated Systems 3-year contracts with LPHAs were renewed to address one of three MCH health issues; injury, obesity and tobacco prevention. Reducing obesity in the MCH population was the focus of 49 contracts with infrastructure building, population-based services and community capacity initiatives addressing obesity on the local level. Promising practices or research-based approaches included interventions that involve policy changes related to physical activity at local businesses or increased access to physical activity programs and resources within the community. Primary focus was bring community partners together to address this issue.

CCHC program provided 302 hours of training for child care providers on nutrition and 107 hours of training for child care providers on the importance of physical exercise.

BHI provided links to this data in the YRBS system.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Child and Adolescent Toolkit developed and made available			X	X
2. MCH Coordinated Systems contracts with 49 LPHAs choose obesity prevention to address with their community partners		X	X	X
3. CCHC program trained child care providers on socializing healthy nutritional and physical activity habits in young children			X	
4. BHI provided links to this data in the YRBS system				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

49 MCH Coordinated Systems 3-year contracts with LPHAs for obesity prevention. Community coalitions implementing evidence-based interventions building on current community-based interventions to increase physical activity in children by school walking clubs, school physical education activities and access to local exercise and physical activity facilities. MCH District Nurse Consultant serves on committee with CASH that developed new guidelines for schools to include physical activity through a coordinated school health program. DESE to include in schools Missouri School Improvement Plan.

Adolescent Health, School Health Services, CASH, MOCAN and MU School of Journalism are developing statewide physical activity and healthy eating media campaign targeting adolescents.

Healthy eating and physical activity for adolescents are addressed in trainings and ADOLESCENT SHORTS.

DHSS Adolescent Health Team and CASH address Adolescent Health System Capacity priorities related to this performance measure. CASH recommendations for new MSIP accreditation standards are being considered.

School Health addressed physical activity and good nutrition using action plans developed at the local level as a result of the School Health Index assessment.

CCHC Program provides group education to child care providers and parents on importance of healthy nutrition and physical activity habits in young children.

BHI provided links to this data in the YRBS system.

c. Plan for the Coming Year

Adolescent Health Program and CASH will work with MOCAN and the Bureau of Health Promotion, on strategies to promote physical activity and healthy eating.

DHSS Adolescent Health Team and CASH will address adolescent health system capacity priorities related to this performance measure.

The school health contractors are implementing work plans based upon their assessment using the CDC Instrument, the School Health Index.147 schools are addressing physical activity and nutrition. The School Health Program is partnering with Action for Health Kids, the Alliance for a Healthier Generation , the Missouri Coordinated School Health Coalition and a health care foundation to evaluate the effectiveness of local school wellness policies and practices. This same partnership is collaborating on a statewide conference to inform others of the results.

The MCH Coordinated Systems contracts with LPHAs address one of three MCH health issues. Reducing obesity in the MCH population is the focus of some contracts with population-based services and community capacity building initiatives addressing obesity on the local level. Interventions will include expanding and building on the current collaborative community-based interventions to increase the amount of physical activity for students through school walking clubs, promoting appropriate physical education activities in schools and increasing access to local exercise and physical activity facilities.

MCH Coordinated System staff will continue to work with LPHAs and local school health staff to improve collaboration and address the issue of increasing physical activity in the student population.

To support this MCH contract priority, LPHAs implementing TOP will integrate activities to promote physical activity and nutrition through youth education and service learning projects.

CCHCs will provide education to child care providers and young parents on the importance of physical activity in young children. They will also provide health promotion programs to young children on this topic.

BHI will continue to provide data from the YRBS system and the YRBS MICA.

State Performance Measure 5: *Percent of women who enrolled in WIC during first trimester of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			51.9	52.1	42.3
Annual Indicator	50.8	42.0	41.6	40.2	40.2
Numerator	18077	19101	18502	18873	18873
Denominator	35601	45478	44477	46948	46948
Data Source					Missouri Pregnancy Nutrition Surveillance System
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	41.6	41.8	42	42.2	42.4

Notes - 2008
Source: CDC. Data Tables of the Missouri Pregnancy Nutrition Surveillance System (PNSS). The 2008 numbers will be available in November 2009, 2007 numbers are used as proxy for 2008.

This measure was selected as it reflects the ability of women to identify and access needed services such as applying for Medicaid, food stamps, TANF and accessing prenatal care.

Missouri had the fifth highest percent WIC enrollment during the first trimester among 28 states participating in PNSS in 2007. In FFY 2008, MO WIC began providing additional funds to local WIC providers to increase WIC enrollment among pregnant women. Objectives 2009-2013 were based on a combination of trend analysis on data 1998-2007 and discussions with the WIC Program.

Notes - 2007
Source: CDC. Data Tables of the Missouri Pregnancy Nutrition Surveillance System (PNSS). 2007 numbers will be available in November 2008. 2006 numbers are used as proxy for 2007.

Missouri had the third highest percent of women enrolled in WIC during first trimester of pregnancy among 29 states/territories participating in the PNSS in 2006. Objectives for 2008-2012 were based on trend analysis using the CDC data table of Missouri PNSS 1997-2006, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Data source was changed from Birth certificate records in MICA and WIC Prenatal MICA to Data Tables of the Missouri Pregnancy Nutrition Surveillance System (PNSS) reported by CDC. The change aimed to 1) use the same data source for both numerator and denominator, 2) define the denominator as the number of women enrolled in WIC in either period during pregnancy or postpartum period instead of only the number enrolled in WIC during pregnancy, and 3) make the indicator comparable with other states/territories with PNSS.

The measures in 2006 and 2005 were also revised based on data from the changed data source. Therefore, 2005 and 2006 numbers are not comparable with numbers reported in 2004 and earlier.

Notes - 2006

2005 numbers used. 2006 numbers not available as of July 2, 2007. Data obtained from birth certificate records reported in MICA (Missouri Information for Community Assessmet).

Annual performance objectives for 2007-2011 are based on a regression analysis of the trend in percent of women who enrolled in WIC during the first trimester of pregnancy in Missouri during 2000-2005. The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

Updated field note as of May 2008:
Changed data source: CDC. Data Tables of the Missouri Pregnancy Nutrition Surveillance System (PNSS). The numbers for 2006 were revised based on the changed data source. The numerator is the number of women enrolled in WIC during first trimester of pregnancy in CY 2006; the denominator is the number of women enrolled in WIC (either during pregnancy or postpartum period) in CY 2006.

Because of the change of data sources, 2006 and 2005 numbers are not comparable with numbers reported in 2004 and earlier.

a. Last Year's Accomplishments
Home Visiting and Alternatives to Abortion programs continued current interventions to refer pregnant and post partum women to WIC.

BHI provided data for this measure from the WIC Prenatal MICA.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Home Visiting and Alternatives to Abortion Programs refer all women who are not currently enrolled to WIC services		X		
2. BHI provided data for this measure from the WIC Prenatal MICA				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
TEL-LINK, DHSS's toll-free telephone line for maternal and child health care provided information and referrals to Missouri women regarding WIC. Literature on the WIC program was distributed at various health fairs and conferences to educate women and the public about WIC services. TEL-LINK collaborated with the WIC program by including the TEL-LINK number in a brochure aimed at educating health care professionals. TEL-LINK targeted the Hispanic population through advertisements in two bilingual newspapers: DOS MUNDOS and the KANSAS CITY HISPANIC NEWS.

BHI continues to provide data for this measure from the WIC Prenatal MICA.

Home Visiting and Alternatives to Abortion programs refer all women who are enrolled in their programs to WIC if not currently enrolled.

c. Plan for the Coming Year
TEL-LINK, DHSS's toll-free telephone line for maternal and child health care will provide information and referrals to Missouri women regarding WIC. The TEL-LINK program will collaborate with the WIC program by including the TEL-LINK number in various brochures and flyers. Literature on the WIC program will be distributed at various health fairs and conferences to educate Missouri women and the public about WIC services.

Alternatives to Abortion programs will continue to refer all women who are enrolled in their programs to WIC if not currently enrolled.

DHSS Home Visiting programs will continue to encourage women to utilize the assistance of WIC. Many of the women are referred to Home Visiting programs by WIC, but if not already enrolled when home visiting starts they are encouraged to do so.

BHI will continue to provide this data from the WIC Prenatal MICA.

State Performance Measure 6: *The incidence of emergency room visits for diseases of teeth and jaw for children ages under 15 per 1,000 population.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			0.9	0.9	0.9
Annual Indicator	1.1	1.0	2.0	1.9	1.9
Numerator	1252	1126	2389	2243	2243
Denominator	1139446	1162408	1169209	1169228	1169228
Data Source					MO DHSS. Patient Abstract System
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	1.7	1.6	1.5	1.4	1.3

Notes - 2008
Source: Missouri Information for Community Assessment (MICA)-Emergency Room, MICA-Population. 2008 data are not available yet, 2007 provisional data are used as proxy for 2008. Final 2008 data will be available in November, 2009.

Numerator is the number of ER visits due to disorders of teeth and jaw. In previous reports, numerator for 2006 and earlier used the category-diseases of the mouth excluding dental. In this report, numerators for 2006 and later have been updated using the more related category - disorders of teeth and jaw. The number/rates of ER visits using the category - disorders of teeth and jaw for 2004 and 2005 should be 2,655/2.3 per 1,000 in and 2,468/2.1 per 1,000 respectively.

Objectives 2009-2013 were created based on trend analysis on data 2004-2007, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007

Source: Source: Missouri Information for Community Assessment (MICA) - Emergency Room, and the Bureau of Health Informatics, MO DHSS. 2007 data will be available in December 2008, and 2006 data is used as proxy for 2007.

Objectives 2008-2012 were created based on trend analysis on data 1994-2006, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2006
Data obtained from birth certificate records reported in MICA (Missouri Information for Community Assessment). 2005 data used in place of 2006 numbers until more current data is available.

Annual performance objectives for 2007-2011 are based on a regression analysis of the trend of incidence of emergency room visits for diseases of teeth and jaw for children < 15 years per 1,000 in Missouri during 1994-2004.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

a. Last Year's Accomplishments
Over 33,840 early childhood learning centers, Head Start, Early Head Start and elementary-high school children received oral health screenings, education, referrals (if necessary) and fluoride varnish applications during school year 2008-2009 to prevent and control the growth of caries/cavities through the Missouri Oral Health PSP. The Missouri Oral Health PSP will be expanded in upcoming fiscal years to include all the Head Start and Early Head Start in the state. 317 schools were provided with FMR in 2007-2008 and 76,110 Missouri children received FMR on a regular basis. Approximately 57,194 children in 253 schools participated in FMR during 2008-2009 school year. Schools are being transitioned from FMR to PSP (fluoride varnish) in the next 5-year period. Schools have been alerted that the 2009-2010 school year will be the final year that FMR will be offered; many schools are working with the Oral Health Program to transition to PSP for the next school year. Efforts are ongoing to implement the PSP in schools statewide. The impact of these services is to be evaluated utilizing emergency room admissions data and, after three years, the surveillance data collected in the program processes.

CCHC program provided 19 hours of adult group education and 321 programs for young children on the importance of good oral hygiene.

MOCCRRN provided information on dental care to families. Inclusion Specialists provide training and technical assistance on dental care for infants through school age child care providers.

BHI provided data for this measure from the Patient Abstract System.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Over 17,655 Head Start, Early Head Start and school children received screenings, education, referrals and fluoride varnish applications to prevent and control the growth of caries/cavities through the Missouri Oral Health Preventive Services		X	X	
2. CCHC program provided adult group education and education for young children on the importance of good oral hygiene			X	
3. MOCCRRN provides information to parents and training to child care providers on dental care		X		
4. Schools participating in FMR program and transitioning to PSP			X	
5. Number of school contracts participating in fluoride varnish			X	

6. BHI provided data for this measure from the Patient Abstract System				X
7.				
8.				
9.				
10.				

b. Current Activities
PSP will continue in Early Children Learning Centers, Head Start Programs, and participating school. Goal is to have all Head Start programs in PSP as soon as programs are ready to implement. PSP will be implemented in those schools ready to transition from FMR program to PSP and in other schools ready to implement PSP (screenings, education, referrals and fluoride varnish applications to prevent and control caries/cavities). PSP is now in 352 communities with 33,840 children participating.

CCHC program provides adult group education and education for young children on the importance of good oral hygiene.

MOCCRRN provides information on dental care to families. Inclusion Specialists provide training and technical assistance on dental care for infants through school age child care providers.

MCH continues to support to the School Health Services Program and child care health and safety program through consultation and technical support to the local child care providers and local School Nurses addressing oral health in their communities.

The School Health Program began a new performance measure for the school health contract in 2008 regarding oral health. Schools may choose to implement oral health promotion programs or increase number of children participating in topical fluoride programs. The program is using power point presentations developed by DHSS for oral health promotion and developing local systems to address the fluoride varnish program in schools.

BHI provides data.

c. Plan for the Coming Year
MCH will continue to support to the School Health Services Program and child care health and safety program through consultation and technical support to the local child care providers and local School Nurses addressing oral health in their communities.

CCHCs will provide education to child care providers and young parents on the importance of dental health in young children. They will also provide health promotion programs to young children on dental health and care of their teeth. Education is also provided to child care providers, parents and young children on safety topics such as fall prevention, safeguarding teeth.

OHP will continue to provide PSP consisting of screenings, education, referrals (if necessary) and fluoride varnish applications to early children learning centers, Head Start Program and schools throughout the state to prevent and control the growth of caries/cavities. Efforts are ongoing to encourage schools currently participating with FMR program to transition to PSP by 2011. School year 2009-2010 will be the final year the FMR program will be offered.

The School Health Program will continue with a contract requirement for schools to offer oral health promotion programs and/or topical fluoride applications. In addition, the program will continue to track the number and percent of children with a oral health provider and number of comprehensive visits

BHI will continue to provide data from the patient abstract system.

State Performance Measure 7: *The incidence of domestic violence per 100,000 population.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			666.4	661.4	660.9
Annual Indicator	683.6	672.3	685.5	633.5	578.2
Numerator	39373	38998	40053	37239	34178
Denominator	5759532	5800310	5842713	5878415	5911605
Data Source					Missouri Highway Patrol
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	573	568	563	558	553

Notes - 2008
Source: Numerator is number of domestic violence incidents obtained from the 2008 report of the Uniform Crime Reporting Program (UCR), Missouri Highway Patrol. Denominator is 2008 population estimate from the US Census Bureau.

Objectives 2009-2013 were based on past performance data 2004-2008, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
Numerator is number of domestic violence incidents obtained from the 2007 report of the Uniform Crime Reporting Program (UCR) , Missouri State Highway Patrol. Denominator is the population estimate for 2007, obtained from the U.S. Census Bureau.

Objectives 2008-2012 were based on trend analysis on data 2001-2007, and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2006
Domestic violence rates obtained from Uniform Crime Reporting Program operated by Missouri State Highway Patrol.

Annual performance objectives for 2007-2011 are based on a regression analysis of UCR data from Missouri during 2001-2005.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

a. Last Year's Accomplishments
MOCCRRN provided training to child care providers on recognizing and reporting child abuse and neglect. The CCHC Program provided 54 hours of adult education on abuse/neglect and 90 programs for young children on recognizing potential abuse situations.

OWH collaborated with many colleges/universities, jr. high/high schools, other state departments and organizations for the rape education & awareness initiative, Denim Day, to educate, promote and empower individuals to Step Forward - Take a Stand Against Rape. The number of events soared from 5 in 2007 to 80 in 2008.

OWH collaborated with IVPP and UMC on the Denim Day initiative and to educate, promote and empower individuals to Step Forward and Take a Stand Against Rape. Denim Day was conducted on 5 college and university campuses in Central Missouri and DHSS.

MCH Coordinated Systems renewed contracts with LPHAs to focus on one of the three issues of injury, obesity and tobacco prevention. Each has contractual obligation to utilize evidence-based interventions. Local systems development with community partners was the primary focus with planning for interventions and environmental and policy changes to impact these issues. Local coalitions formed to address child abuse and neglect.

The School Health Services Program continues to promote in regional workshops and via list serves, information regarding Denim Day for School Nurses and School Social Workers. Twenty school districts observed Denim Day.

School Health Services Program hosted a one-day workshop for School Social Workers on "Domestic Violence 101" and The Effects on Children Witnessing Intimate Partner Violence.

TOP contractors address bullying prevention.

Abstinence education contractors present sessions on dealing with pressures and healthy relationships.

All women enrolled in the MCBHV and the Building Blocks Programs were assessed for domestic violence.

Through community coalitions' contracts, Governor's Substance Abuse Prevention Initiative addresses risky drinking behaviors, possible precursors to interpersonal and domestic violence.

IVPP supported 19 SAP and 25 SAV grantees with contracts to implement activities to prevent violence against women. Communities were implementing primary prevention interventions linked to the state Violence Against Women plan. Conferences/trainings enhanced capacity of health and human service providers to develop safe and effective prevention, screening, interventions and follow-up strategies for sexual assault.

Goals: provide professionals opportunities for discussion and collaboration; establish coordinated community response; promote partnerships among agencies; increase understanding issues faced by victims. The Sexual Assault Forensic Examination program paid hospitals and appropriate medical providers for the collection of evidence for cases of alleged sexual assault.

A one-day educational seminar was presented by representatives of the Sinclair School of Nursing DOVE study to educate Alternatives to Abortion providers on assessing for domestic violence.

A one day "diversity training" will be held for home visiting and alternatives to abortion contractors in September 2009. Diversity as it relates to domestic violence will be included.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MOCCRRN provides training to child care providers on recognizing and reporting child abuse and neglect		X		
2. OWH collaborated with Injury/Violence Prevention and UMC to educate and empower individuals to Step Forward and Take a Stand Against Rape; 80 Denim Day events were held across			X	

Missouri				
3. The School Health Program provided in regional workshops regarding Denim Day for School Nurses and School Social Workers. Eleven school districts observed Denim Day		X	X	
4. School Health Services hosted one-day workshop for School Social Workers on “Domestic Violence 101” and The Effects on Children Witnessing Intimate Partner Violence		X	X	
5. All women enrolled in the MCBHV and the Building Blocks Programs were assessed for domestic violence		X	X	
6. IVPP had agreements with communities to develop plans to prevent violence against women. IVPP contracted with communities that had plans to begin action. Primary prevention interventions began link to the state VAW plan to reflect community alliance			X	X
7. The CCHC Program provides education to child care providers on recognizing signs of child abuse/domestic violence and for children on avoiding potential abuse situations			X	
8. 2nd Annual Sexual Assault Prevention Conference enhanced skills & knowledge of professionals who provided prevention services and worked with individuals experiencing domestic violence, sexual violence, child abuse & other violent situations		X		
9. Conferences for School Staff on Bullying Prevention and Dating Violence		X		
10. MCH Coordinated Systems renewed LPHA contracts focused on injury, obesity and tobacco prevention. Some LPHAs choose to address child abuse and neglect with their community partners		X	X	X

b. Current Activities

TEL-LINK provides information/referrals for domestic violence shelters and resources on sexual assault centers. The toll-free number and educational literature were available at the Health Summit-Preventing Violence Against Women.

MOCCRRN trains child care providers on Recognizing and Reporting Child Abuse and Neglect, Shaken Baby Syndrome, Supportive Responses to Troubled Parent-Child Interactions.

OWH and IVPP continue Denim Day events in schools statewide; develop a new website, facebook and myspace presence; other injury/violence prevention advocates, state agencies, LPHAs; and OWH nationally.

Nurses in School Health and MCH are being certified in Olweus Bullying Prevention.

TOP implement bullying prevention strategies.

Abstinence contractors present sessions on pressures and healthy relationships.

Adolescent Health Team and CASH address priorities related to this performance measure.

Home Visiting programs participate with UM-Sinclair School of Nursing and Johns Hopkins University funded through NIH to assess enrolled women for domestic violence and enroll in research-based DOVE intervention.

SAV Services provides advocacy services, face-to-face counseling and support groups for victims and families of sexual violence; SAP and Education funding was renewed; continue to engage men and faith-based communities as allies.

40 contracts with LPHAs address injury prevention.

State School Nurse Consultant provides session for new school nurses on their role in Child Abuse and Neglect.

c. Plan for the Coming Year

TEL-LINK, DHSS's toll-free telephone line for maternal and child health care, will provide information and referrals regarding the availability of domestic violence shelters and sexual assault centers.

Alternatives to Abortion programs will attend a seminar on domestic violence and will be educated on training on all clients for domestic violence.

Related topics will be presented in the ADOLESCENT SHORTS newsletter and during training on current adolescent health issues through the Adolescent Medicine and Health Consultation contract with Children's Mercy Hospital.

TOP projects will implement strategies for bullying prevention.

Home Visiting programs will continue to screen women for domestic violence and continue to be involved in domestic violence research study funded by the National Institute of Health through the UM-Sinclair School of Nursing and Johns Hopkins University. The DOVE study is funded for 5 years.

Alternatives to Abortion providers will continue to screen all women who enroll in the program for domestic violence.

Adolescent Health, IVPP and OWH will continue to identify collaborative campaigns and educational strategies to promote Denim Day, prevent sexual assault and dating violence.

DHSS Adolescent Health Team and CASH will address Adolescent Health System Capacity priorities related to this performance measure.

The school health contractors are implementing work plans based upon their assessment of policies and practices using the CDC tool, the School Health Index.

All school districts now must have bullying prevention policies. Many School Social Workers and School Nurses are part of the bullying prevention teams. School Health Services is actively engaged in the Olweus Bullying Prevention Program. Several schools participated in the Denim Days initiative. This year, the School Health Program will promote the use of a school and community program related to sexual abuse of children, Stewards of Children.

SAV Services contracts will be rebid for FY10. Advocacy, face-to-face counseling and support group services for victims and family members are the focus of this federal funding.

SAP and Education contracts (19) have been renewed for FY10. Each contractor identifies specific targets and milestones based on their community needs. Engaging men and faith-based communities as allies remains a priority in addition to work being done with teens and at-risk youth and adults.

OWH, IVPP, and Adolescent Health will collaborate to hold events on Denim Day and utilize Denim Day materials to educate, promote and empower individuals to Step Forward and Take a Stand Against Rape. Abstinence education contractors have requested related training. This

Denim Day initiative will take place the fourth Thursday of April each year. Participants in this initiative will include universities, other injury/violence prevention advocates, businesses, local public health agencies, and public and private organizations on both state and national levels.

State Performance Measure 8: *Percent of women 18-44 years of age who reported frequent mental distress (FDM) for fourteen or more days during the past thirty days their mental health was not good.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			13	12.8	12.5
Annual Indicator	14.1	13.0	15.4	12.5	15.4
Numerator	307312	284935	165284	133682	164228
Denominator	2185986	2185654	1073275	1066415	1066415
Data Source					MO Behavioral Risk Factor Surveillance System
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	15	14	13	12	11

Notes - 2008
Source: "Percent of women 18-44 years of age reporting their mental health was not good =>14 days in the past thirty days" was obtained from the 2008 Behavioral Risk Factor Surveillance System Survey (BRFSS), Denominator is estimated from the 2007 population of women 18-44 years of age from Missouri Information for Community Assessment (MICA) population. The 2008 population number will be available November, 2009. Numerator is based on BRFSS percentage.

This measure was selected as it reflects the mental health of all women of reproductive age, not merely those in the perinatal period. The results of this measure are applicable to all women in the pre-conception stage and reflect implications for care.

The increase in the percentage from 2007 to 2008 was not statistically significant. Objectives 2009-2013 were based on measures in past years and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
Percent of women 18-44 years of age reporting their mental health not good>=14 days in the past 30 days was obtained from the 2007 BRFSS. Denominator was determined using population estimate of women 18-44 years of age for 2006, obtained from the Missouri Information for Community Assessment (MICA) - Population. 2007 population estimate for specific age groups will be available in November 2008.

A decrease of 0.1% every two years was set to create objectives 2008-2012, based on measures in past years and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2006
Rates obtained from annual BRFSS survey data and MICA population data in denominator (2005 data used until more current numbers available).

Annual performance objectives for 2007-2011 are based on a regression analysis of BRFSS data from Missouri during 2000-2004.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

a. Last Year's Accomplishments
Maternal Child Health and School Health Programs worked with Heartland Centers at St. Louis University School of Public Health, UM Center for the Advancement of Mental Health Practices in Schools, Missouri School Success Network and DMH to provide regional workshops to discuss new ways of collaborating on issues that affect mental health of Missouri's families. Emphasis was placed upon strategies for early identification of mental health issues and identification of what is necessary to achieve and maintain a mentally healthy outlook. The workshops focused on hands-on tools to promote resiliency, strong families and healthy communities. All participants received copies of Bright Futures in Practice: Mental Health.

MCH Coordinated Systems and the School Health Services Program partnered with the UM Center for the Advancement of Mental Health Practices in Schools to foster the development of district/regional leadership teams involving regional staff from mental health, public health, education and Head Start.

CCHC program provided 23 hours of group education on supporting good mental health and stress reduction for child care providers.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. HRSA Technical Assistance and Consultation grant to address mental health and promoting resiliency in communities			X	X
2. MCH Coordinated Systems partnered with UM Center for Advancement of Mental Health Practices in Schools to foster development of district/regional leadership teams involving regional staff from mental health, public health, education and Head Start			X	X
3. CCHC program provided group education on supporting good mental health and stress reduction for child care providers			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
MCH Coordinated Systems provides optional regional meetings for LPHAs that are facilitated by the MCH District Nurse Consultants, with discussion topics focused on issues specific to MCH system development, as requested by LPHAs. Staff will offer consultation and technical support to LPHAs, School Nurses and community collaborations who wish to address mental wellness through identifying what is necessary to achieve and maintain a mentally healthy outlook, early identification of mental health issues and promoting resiliency for strong families and healthy communities.

CCHC program provides group education on supporting good mental health and stress reduction for child care providers.

TEL-LINK, DHSS's toll-free telephone line for maternal and child health care, provides information and referrals to Missourians concerning mental health services.

The Home Visiting programs require routine screening for depression on all program participants. Screening will be added to the Alternatives to Abortion client assessment in July 2009.

c. Plan for the Coming Year
TEL-LINK will provide information and referrals to Missourians concerning mental health services as requested.

School Health Services Program and State School Nurse Consultant are partnering with a multidisciplinary group of agencies on the "Show Me Bright Futures Project" and trying to shift a paradigm from a focus on mental illness to mental health promotion. The materials and concepts for this project are based upon the Bright Futures in Practice: Mental Health work done by MCH and HRSA.

Home Visiting programs will continue to require routine screening for depression on all participants. Women who screen positive are referred to their primary health care provider for referral to a mental health provider if indicated. Routine screening of all Alternatives to Abortion clients for mental health status will be completed upon admission to the program. Contractors will continue to screen all women for post partum depression at six week post partum using the Edinburgh post partum depression screening tool.

The Bureau of Genetics and Healthy Childhood, Office of Epidemiology, and Office of Community Health Information are working collaboratively to develop a perinatal depression web page which will be posted on the DHSS website by September 30, 2009.

Newborn Health will continue to provide brochures and literature on postpartum depression.

MCH Coordinated Systems program staff will continue to participate on the Bright Futures in Practice: Mental Health state planning team to address mental wellness through identifying what is necessary to achieve and maintain a mentally healthy outlook, early identification of mental health issues and promoting resiliency for strong families and healthy communities. Bright Futures training materials for community pilot projects will be provided by the MCH program until the supply is exhausted.

CCHCs will provide training for child care providers and young parents on mental health and stress reduction.

BHI will continue to provide data from the Behavioral Risk Factor Surveillance System (BRFSS) and the BRFSS MICA.

State Performance Measure 9: *Percent of special needs children ages 3-5 enrolled in public preschool programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2004	2005	2006	2007	2008

Performance Data					
Annual Performance Objective			5.9	6.2	5
Annual Indicator	4.8	4.8	4.8	4.9	4.7
Numerator	10790	10887	10873	11315	10944
Denominator	224535	226072	228356	232099	232099
Data Source					MO Dept. of Elementary & Secondary Education
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	4.7	4.8	4.8	4.9	4.9

Notes - 2008
Source: Numerator from the Missouri Dept of Elementary & Secondary Education, Division of Special Education. Students with Disabilities Child count provisional 2008. Denominator is population 2007 estimate from U.S. Census used as proxy for 2008. Final numbers will be available November 2009.

An increase of 0.1% every two years were set to create objectives 2009-2013, based on trend analysis on data 2002-2008 and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2007
Source of numerator: Missouri Department of Elementary and Secondary Education, Division of Special Education. Students with Disabilities Child Count as of December 1, 2007.

Denominator of the population estimate for children ages 3-5 in 2007 will be available in November 2008, and 2006 data is used as proxy for 2007.

Objectives 2008-2012 were based on trend analysis on data 2001-2007 and discussions with the Section of Healthy Families and Youth, MO DHSS.

Notes - 2006
Data obtained from Missouri Department of Elementary and Secondary Education.

Annual performance objectives for 2007-2011 are based on a regression analysis of the trend of percent of special needs children ages 3-5 enrolled in public preschool programs during 2000-2004.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

a. Last Year's Accomplishments
SHCN:
--maintained MO Assistive Technology contract to improve access and independence of cyschn by increasing their functional capabilities and reducing barriers, which may have promoted participation in public preschool programs for cyshcn. Contract was monitored to assure quality.
--maintained cyshcn SC contracts. Contracts were monitored to assure quality. Comprehensive CATs, Service Plans and Transition Plans were completed through collaboration with participants. Participants were linked with resources, which may have included public preschool programs. SHCN trained, mentored and provided technical assistance opportunities for contract agency staff.
--distributed the Preventive Services Checklist and maintained the document on the SHCN Web

site.
--began Phase 2 of the statewide electronic database enhancement to focus on Financial Management.
--administered the CSHCN-Hope Program (RSMo, CCS) and the HCY Program; assisted cyshcn in identifying and accessing services and supports, increasing health care options and independence, which may have increased participation in public preschool programs. The CSHCN-Hope Program provided early identification and health services, including service coordination, diagnostic and treatment services involving medical care, hospitalization and aftercare to participants who required sub-specialty, specialty, preventive and primary care. SHCN provided ACM for HCY Program participants through a DSS MHN ACM was provided through a cooperative agreement. SHCN authorized medical necessity of in-home nursing services and provided service coordination for program participants.
--partnered with FVM and UMKC who received a grant to establish a FTF Health Information Center. The goal of the project is to provide information, training, and personal support to families of cyshcn.
--partnered with UMKC who received a SIG. The goal of this project is to improve and sustain access to quality, comprehensive, coordinated community based systems of services for cyshcn and their families in Missouri.
--partnered with the UMC Thompson Center who received a Autism Grant.
--collaborated with external agencies regarding transitions of participants. SHCN used several transition planning tools, partnered with participants and agencies to complete Transition Plans. Transition planning included preparing for public preschool programs. SHCN linked families with First Steps, Head Start, PAT and other resources as appropriate for cyshcn. SHCN revised policy to incorporate a broad scope of transition needs for SHCN participants; ensuring transition planning was continuous and appropriate for each participant.
--completed assessment tools with SHCN participants.

UMKC coordinated the formulation and completion of a statewide ECCS plan. The MO ECCS Plan structure is a natural continuum from child and family, through community and state. Implementation phase will include collaboration among state agencies and stakeholders to develop plans for data collection and public education in focus areas of MH, parenting information, family support, early childhood programs and social and emotional mental health.

DHSS continued to contract in 2007 with MSU to provide technical assistance, training and consultation services to birthing hospitals and centers operating universal newborn hearing screening programs.

MOCCRRN provided referrals to public preschool programs to families with children with special needs, explaining the types of care available (home, center-based and public preschool), in addition to assisting families in finding vacancies. MOCCRRN also provided technical assistance to public pre-school teachers who care for children with special needs. CCHC Program provided group education to child care providers on the care of cyschn.

TEL-LINK provides information and referrals to Missourians regarding SC for special health care needs.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assistive Technology for CSHCN	X	X		X
2. CSHCN Service Coordination Contracts		X		X
3. Early Childhood Comprehensive Service Grant (ECCS)		X		X
4. Preventive Services Checklist		X	X	
5. HCY and CSHCN-Hope Programs assist CSHCN to identify	X	X		

and access services and supports increasing health care options and independence which may increase participation in public preschool programs				
6. Transition Plans		X		X
7. MOCCRRN provided referrals to families with CSHCN between the ages of 37 months and five years. Public preschool programs were integrated into the referral database		X		
8. CCHC Program provided group education to child care providers on the care of CSHCN		X		
9.				
10.				

b. Current Activities
SHCN continues to:
--maintain and monitor MO Assistive Technology contract and cyshcn SC contracts.
--disseminate Preventive Services Checklist and maintain document on SHCN Web site.
--administer CSHCN-Hope Program and HCY Program.
--partner with FVM and UMKC on the FTF grant.
--partner with UMKC on the SIG.
--partner with the UMC on the Autism Grant.
-- collect assessment information using SCA.
--collaborate with external agencies and participates to obtain information about cyshcn transitioning.

Staff participate in ECCS Plan review by CBEC. DHSS contract with UMKC to improve early childhood outcomes by developing replicable and sustainable infrastructure for local communities.

TEL-LINK provides information and referrals regarding service coordination for SHCN. TEL-LINK targeted the Hispanic population in advertisements in two bilingual newspapers: DOS MUNDOS and the KANSAS CITY HISIPANIC NEWS.

MOCCRRN provides referrals to public preschool programs to families with CSHCN and on-site technical assistance and training to public pre-school teachers who care for CSHCN. CCHC Program provides group education and individual consultation to child care providers on the care of CSHCN. These efforts also address the state priority needs of "Supporting Adequate Early Childhood Development and Education in Missouri", "Improving the Mental Health Status of MCH Populations in Missouri" and "Reducing Intentional and Unintentional Injuries Among Infants, Children, and Adolescents in Missouri".

c. Plan for the Coming Year
TEL-LINK will provide information and referrals to Missourians regarding service coordination for children with special health care needs as requested.

MOCCRRN will continue to provide referrals to public preschool programs to families with children with special needs. MOCCRRN will also continue to explain the types of care available (home, center-based and public preschool) to parents, in addition to assisting families in finding openings. MOCCRRN will also continue to provide on-site technical assistance and training to public pre-school teachers who care for children with special needs. These efforts also address the state priority needs of "Supporting Adequate Early Childhood Development and Education in Missouri", "Improving the Mental Health Status of MCH Populations in Missouri" and "Reducing Intentional and Unintentional Injuries Among Infants, Children, and Adolescents in Missouri".

CCHCs provide consultation and education to child care providers, including preschool programs,

on the care of CSHCN. They will also assist preschool teachers with the creation of individualized health care plans for children in the preschool setting.

SHCN will:
--maintain and monitor the MO Assistive Technology contract to continue improving access and enhance independence of the cyshcn population.
--maintain and monitor CSHCN SC contracts.
--collaborate with participants in the completion of SCA, Service Plans and Transition Plans.
--link participants with resources that may include public preschool programs through service coordination.
--complete implementation of Phase 2 of the statewide electronic database enhancement to focus on Financial Management.
--begin development of Phase 3 of the statewide electronic database enhancement which includes eligibility and participant management.
--complete the integration of assessment data into an all-inclusive participant database and continue statewide data collection using a Web-based SCA that includes information regarding their educational and vocational needs.
--distribute Preventive Services Checklist from SHCN Web site and periodically review/update the document as needed.
--administer the CSHCN Program.
--continue the cooperative agreement with DSS-MHD for ACM through the HCY Program.
--collaborate with external agencies to obtain information about cyshcn transitioning within the systems of care.
--partner with FVM and UMKC on the FTF Grant.
--partner with UMKC on the SIG.
--partner with the UMC Thompson Center on the Autism Grant.

Staff will participate in ECCS Plan review by Coordinating Board for Early Childhood; the Board adopted the plan for implementation. DHSS will maintain a contract with UMKC to improve early childhood outcomes by developing a replicable and sustainable infrastructure for local communities to implement the ECCS Plan.

State Performance Measure 10: *Percent of children ages 0-19 years old who received health care at a FQHC.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			7.1	7.5	8.2
Annual Indicator	6.3	6.4	7.2	7.8	8.4
Numerator	98456	98456	113777	123458	133248
Denominator	1555804	1545754	1574087	1583410	1583410
Data Source					Missouri Primary Care Association
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	8.8	9.2	9.6	10	10.4

Notes - 2008
Source: Numerator is 2008 data from Missouri Primary Care Association. Denominator is 2007 population estimate 0-19 from US Census used as proxy for 2008. 2008 population estimate will

be available in November, 2009.

Objectives 2009-2013 were based on trend analysis on data 2001-2008 and discussions with the Section of Healthy Families and Youth, MO DHSS and Missouri Primary Care Association.

Notes - 2007
Numerator is the number of children 0-19 years of age receiving health care at a FQHC in 2007, obtained from the Missouri Primary Care Association. The denominator of population estimate for children 0-19 for 2007 will be available in November 2008, and 2006 data is used as proxy for 2007.

Objectives 2008-2012 were based on trend analysis on data 2001-2007 and discussions with the Section of Healthy Families and Youth, MO DHSS and Missouri Primary Care Association.

Notes - 2006
Numerator data obtained Uniform Data System Missouri Rollup Reports published by Bureau of Primary Health Care. Denominator obtained from MICA (Missouri Information for Community Assessment) population database.

2006 data is not available for denominator, therefore 2005 data is used until more current numbers are available.

2007-2011 annual performance objectives based on a regression analysis of 2001-2004 data from the Uniform Data System reports.

The MO Department of Health and Senior Services is in the process of revising the annual performance objectives for next year.

a. Last Year's Accomplishments
DCPH entered into a contract with UMKC to design and implement a survey of institutional providers to determine what efforts are being made to recruit, place and retain primary care (PC) serving MCH populations in Missouri.

A new chief for OPCRH (Marie Peoples) was hired to replace Harold Kirbey who was promoted to deputy director for DCPH.

OPCRH partnered with MPCA and Missouri Area Health Education Center (MAHEC) to support recruitment, placement and retention of PCPs, nurses, dentists and dental hygienists in underserved areas. During 2006-2007, 10 dentists were placed in underserved and rural communities. During 2008-2009, 6 dentists have been placed in underserved and rural communities.

A plan for the evaluation of the rural health program was finalized. This evaluation included an assessment of where the strategic direction of the rural health program needs to be refocused.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. OPCRH supported expansion of services and sites of FQHCs				X
2. FQHCs assisted OPCRH in implementing PSP in Head Start				X
3.				
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
Products produced from the contract with UMKC have been reviewed for application to underserved areas in Missouri to improve recruitment, placement and retention of PCPs in those areas. The Population Based Oral Health Workforce Plan is currently being updated by UMKC.

OPCRH has realigned its resources to support Missouri HealthNet reforms such as the "Healthcare Incentives Access Fund."

The evaluation of the rural health program has been completed as part of the realignment of resources in OPCRH.

With the support of OPCRH, three dental clinics have been funded in 2007-2008 with additional FQHCs requesting support for 2008-2009. This will have a definite impact on improving access to dental care.

c. Plan for the Coming Year
School Health Services Program will continue to host meetings for School Nurses and School Social Workers. One of the topics will be access to care. A representative from the FQHC will present an overview of their system. Additionally, the FQHC system will submit articles in the School Nurse Update E Newsletter sent to all School Nurses. This E newsletter is a new initiative for the School Health Services Program and is well received by School Nurses.

OPCRH will continue to work with area health education centers, FQHCs and LPHAs to improve recruitment, placement and retention of health care professionals in underserved areas in Missouri.

E. Health Status Indicators

Introduction
BHI is primary source for health data within the state. BHI oversees the statistical support and health care assurance activities of DHSS; collects, analyzes and distributes health-related information that promotes better understanding of health problems and needs in Missouri; and highlights improvements and progress achieved in the general health status of Missourians.

To assure uniform and consistent reporting of all Title V related data, DCPH Director's Office works with ITSD to integrate the eleven core health systems capacity indicators and some of the health status indicators into MOHSAIC.

Data generated by the BHI aid and guide the planning, development and evaluation of programs and services of the department as well as the health-related activities of other agencies, institutions and organizations.

DCPH/ITSD provides continued integration of multiple single-purpose databases into a single system which supports a child-centered record.

MOHSAIC utilizes a data warehouse augmented with surveillance data such as births, deaths, immunization, hospital patient abstracts, cancer registry, etc. Data fields are configured to allow analytic tools to retrieve data in an aggregated format useful for assessment and policy development purposes. Selected data from the MOHSAIC information warehouse is moved to the DHSS Web page for external users to access.

/2008/
MOHSAIC utilizes a data warehouse augmented with surveillance data such as births, deaths and immunization.
//2008//

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	8.3	8.1	8.1	7.9	8.1
Numerator	6440	6372	6579	6456	6581
Denominator	77709	78549	81353	81883	80868
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source: Missouri Information for Community Assessment (MICA) - Births,
DHSS Vital Statistics. 2008 provisional data as of April 2009 Final birth data will be available in October 2009.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Births,
and the Bureau of Health Informatics, MO DHSS. 2007provisional data as of April 28, 2008. 2007 final birth data will be available in October 2008.

Narrative:
For the above health status indicators, increase is generally attributed to changes in medical management of pregnancies.

Among the programs and activities that strive to improve the health of pregnant women and access to care and thereby reduce low weight births are:
--Home Visiting
--TEL-LINK
--ATODPA
--Newborn Health
--Alternatives to Abortion

MCH Coordinated Systems Contracts with LPHAs --Title V funds support LPHAs for the purpose of establishing and maintaining a system capable of addressing adequate prenatal care. Two performance measures were addressed in jurisdictions where the data was most disparate:
-Increase the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester (11 LPHAs) and
-Decrease the percent of pregnant women receiving inadequate prenatal care (13 LPHAs).

/2008/
Contracts with LPHAs have been renewed with the focus on the objectives on injury, obesity and tobacco. Local contractors will continue to address the issue of adequate prenatal care with local funds.
//2008//

/2010/
In 2009, contracts with LPHAs continue to focus on injury, obesity and tobacco prevention.
LPHA contractors will continue to address the issue of adequate prenatal care with local funds.
//2010//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	6.5	6.3	6.3	6.2	6.4
Numerator	4865	4761	4938	4890	4985
Denominator	75091	75805	78577	79204	78088
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source: Missouri Information for Community Assessment (MICA) - Births,
DHSS Vital Statistics. 2008 provisional data as of April 2009 Final birth data will be available in October 2009.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Births,
and the Bureau of Health Informatics, MO DHSS. 2007 provisional data as of April 28, 2008.
2007 final birth data will be available in October 2008.

Narrative:
/2010/
See Health Status Indicator #01A
//2010//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.5	1.5	1.5	1.5	1.4
Numerator	1186	1196	1190	1242	1159
Denominator	77709	78549	81353	81883	80868
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source: Missouri Information for Community Assessment (MICA) - Births,
DHSS Vital Statistics. 2008 provisional data as of April 2009 Final birth data will be available in October 2009.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Births,
and the Bureau of Health Informatics, MO DHSS. 2007provisional data as of April 28, 2008. 2007 final birth data will be available in October 2008.

Narrative:
/2010/
See Health Status Indicator #01A
//2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.1	1.1	1.1	1.1	1.1
Numerator	854	862	893	903	863
Denominator	75091	75805	78577	79204	78088
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source: Missouri Information for Community Assessment (MICA) - Births,
DHSS Vital Statistics. 2008 provisional data as of April 2009 Final birth data will be available in October 2009.

Notes - 2007

Source: Missouri Information for Community Assessment (MICA) - Births,
and the Bureau of Health Informatics, MO DHSS. 2007provisional data as of April 28, 2008. 2007 final birth data will be available in October 2008.

Narrative:
/2010/
See Health Status Indicator #01A
//2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	12.5	10.1	10.5	13.3	12.7
Numerator	143	114	123	155	149
Denominator	1141490	1129720	1169209	1169228	1169228
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source: Missouri Information for Community Assessment (MICA) - Deaths. DHSS Vital Statistics. Numerator includes motor vehicle accidents & all other unintentional injuries. 2008 provisional data as of April 2009 Final death data will be available in October 2009.
Denominator is population estimate from MICA tables-population. 2007 being used as proxy for 2008. 2008 final population data will be available November 2009.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Deaths, MICA - Population, and Bureau of Health Informatics, MO DHSS. Numerator is based on 2007 provisional death data as of April 28, 2008. Denominator population estimate for children <=14 years of age for 2007 is not available yet, and population estimate for 2006 is used as a proxy for 2007. 2007 final data will be available in November 2008.

Notes - 2006
2005 estimate substituted into denominator until more current information available.

Narrative:
----Source: Injury MICA.

Injury Prevention Projects -During FY05, the Injury and Violence Prevention program provided direct contractual support for the following local injury and violence prevention activities with MCH Block Grant funding.

/2008/

Injury and Violence Prevention program continued direct contractual support.
//2008//

Injury and Violence Prevention in School Environments --The program had agreements with 41 Missouri schools to assess the school environment related to injury and violence prevention using the School Health Index: A Self Assessment and Planning Tool. Schools developed action plans for implementing the recommendations from the School Health Index assessment. The School Health Advisory Council and the school board approved the action plans.

Community Planning Grants for Preventing Violence Against Women (VAW) --The program had agreements with eight communities that demonstrated strong partnerships and collaboration to develop community-wide plans that included evidence-based interventions to prevent violence against women.

Implementation Grants for Preventing Violence Against Women --Five communities that have existing community-wide plans to prevent violence against women received contracts to implement activities contained in those local plans. Primary prevention interventions implemented link to the state VAW plan and reflect community collaboration.

The Injury and Violence Prevention Program provides technical assistance and training as well as materials to support local interventions. This included the purchase of the music video, "The Eleventh Commandment" by Collin Raye for all child advocacy centers and sexual assault prevention contractors to use in sexual assault prevention activities at the local level. The book, BLUEPRINTS FOR VIOLENCE PREVENTION, BOOK NINE: BULLY PREVENTION PROGRAM was purchased for participants at a bullying prevention training.

The Injury and Violence Prevention Program worked with the School Health and Maternal and Child Health programs to conduct a professional development opportunity for school nurses, public health professionals and injury and violence prevention practitioners. The conference, Schools and Public Health: Connection for Healthier Communities, was held in March 2005. The conference included an injury and violence prevention track. The program used MCH funds to support scholarships for injury and violence prevention practitioners to attend the conference and to network with school health and maternal and child health practitioners.

/2009/
The IVPP staffs made several injury and violence prevention presentations during 2007statewide MCH Spring meetings to various LPHAs' employees and provided handouts, brochures, safety materials and information.
//2009//

/2010/
See Health Status Indicator #03B, 03C, 04A, 04B, and 04C.
//2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	4.4	3.7	3.6	3.7	3.1
Numerator	50	43	42	43	36
Denominator	1141490	1162408	1161209	1169228	1169228

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source: Missouri Information for Community Assessment (MICA) - Deaths. DHSS Vital Statistics. Numerator includes deaths due to motor vehicle accidents. 2008 provisional data as of April 2009 Final death data will be available in October 2009.
Denominator is population estimate from MICA tables-population. 2007 being used as proxy for 2008. 2008 final data will be available November 2009.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Deaths, MICA - Population, and Bureau of Health Informatics, MO DHSS. Numerator is based on 2007 provisional death data as of April 28, 2008. Denominator population estimate for children <=14 years of age for 2007 is not available yet, and population estimate for 2006 is used as a proxy for 2007. 2007 final data will be available in November 2008.

Notes - 2006
2005 estimate substituted into denominator until more current information available.

Narrative:
----Source: Injury MICA.

SAFE KIDS Missouri --The program contracts with the nine local SAFE KIDS coalitions in Missouri to assist with building local infrastructure. The contracts require coalitions to identify the injury prevention needs in their areas, conduct interventions to address those needs and conduct program evaluation. During 2005, the program funded the purchase of 400 child passenger safety seats for each of the nine SAFE KIDS Coalitions in Missouri (3,600 total) to help assure low income Missourians have access to child occupant protection. In addition, a large quantity of print materials was purchased for the coalitions. During FY2005, MCH funds were used to support a professional development conference for the coordinators and other members of the nine local SAFE KIDS coalitions.

/2008/
During FY2006, with MCH funds nine SAFE KIDS coalitions were able to reach a population of100,516. Also MCH funds were used to support a professional development conference for the coordinators and other members of the nine local SAFE KIDS coalitions.
//2008//

/2009/
Safe Kids Missouri--The program contracts with eight local Safe Kids coalitions in Missouri to assist with building local infrastructure.

During FY2007 with MCH funds, the Safe Kids coalitions were able to reach a population of134,876. During FY2007, MCH funds were also used to support a leadership workshop for the coordinators and other members of the eight local Safe Kids coalitions.
//2009//

/2010/

Safe Kids Missouri--The program contracts with nine local Safe Kids coalitions in Missouri to assist with building local infrastructure.

During FY 2008 with MCH funds, the Safe Kids coalitions were able to reach a population of 94,240. During FY2008, MCH funds were also used to support a leadership workshop for the coordinators and other members of the eight local Safe Kids coalitions.

See Health Status Indicator #03A, 03C, 04A, 04B, and 04C.
//2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	37.0	40.6	36.1	30.7	29.5
Numerator	309	335	297	250	240
Denominator	835011	824951	823814	813974	813974
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source: Missouri Information for Community Assessment (MICA) - Deaths. DHSS Vital Statistics. Numerator includes deaths due to motor vehicle accidents. 2008 provisional data as of April, 2009 Final death data will be available in October 2009.
Denominator is population estimate from MICA tables-population. 2007 being used as proxy for 2008. 2008 final data will be available November 2009.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Deaths, MICA - Population, and Bureau of Health Informatics, MO DHSS. Numerator is based on 2007 provisional death data as of April 28, 2008. Denominator population estimate for youth 15-24 years of age for 2007 is not available yet, and population estimate for 2006 is used as a proxy for 2007. 2007 final data will be available in November 2008.

Notes - 2006
2005 estimate substituted into denominator until more current information available.

Narrative:
----Source: Injury MICA.

Think First Missouri --The program contracted with the UMC School of Medicine to conduct ThinkFirst Missouri activities. This program provides primary prevention activities targeted to elementary and secondary school students related to the prevention of head and spinal cord injuries.

/2008/

In 2006 Think First Missouri reached a population of 17,364 through school assemblies and other activities.
//2008//

/2009/
Revised 2006 number is 17,456.

Think First Missouri continues to provide school-based safety and prevention assemblies for junior high, middle and senior high school students.
//2009//

/2010/
In 2008, ThinkFirst Missouri reached a population of 17,197.

See Health Status Indicator #03A, 03B, 04A, 04B, and 04C.
//2010//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	203.2	204.2	197.5	199.9	199.9
Numerator	2320	2374	2309	2337	2337
Denominator	1141490	1162408	1169209	1169228	1169228
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Source: DHSS. Missouri Information for Community Assessment (MICA) - Injuries, Patient Abstract System, & MICA-Population. Numerator is 2007 provisional injury data as a proxy for 2008. Denominator is population estimate of children age 14 year & under in 2007, as a proxy for 2008. 2008 data will be available November 2009.

The numerator is estimated by taking number of inpatient hospitalizations for unintentional injuries minus the number died from the injuries among children aged <=14 years.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Injury, MICA - Population, and Bureau of Health Informatics, MO DHSS. 2007 data are not available yet, and 2006 data are used as proxy for 2007. 2007 final data will be available in December 2008.

The numerator is estimated by taking number of inpatient hospitalizations for unintentional injuries minus the number died from the injuries among children aged <=14 years.

Notes - 2006

2005 estimate substituted into denominator until more current information available.

Narrative:
Regional Conference: Interventions to Prevent Violence Against Women --This conference was designed to enhance the skills and knowledge of professionals who work with individuals experiencing domestic violence, sexual violence, child abuse and other violent situations.

Professionals are provided tools regarding how to respond to victims, victim empathy, resources, the victim response and behavior and how to provide appropriate services to an individual who has experienced or witnessed violence. In addition, a large part of the conference focused on violence prevention. The program worked with Mercy Health Plans, The Child Center, the Southeast Missouri Network Against Sexual Assault and St. Francis Medical Center to conduct: Prevention and Interventions for Ending Violence Against Women, Children and Families and hosted local, statewide and national speakers.

During FY2005, the program partnered with the Special Health Care Needs Unit (SHCN) to assess the safety needs of children with special health care needs and acquire equipment to increase the safety of those children. Service coordinators in the SHCN Unit documented unmet needs and coordinated the purchase of safety equipment for children with special health care needs and their families. Items purchased included 166 baby gates, 202 child safety kits, 488 first aid kits, 119 helmets and pads, 52 infant head supports, 321 smoke/carbon monoxide detectors and 207 thermometers.

Through a collaborative relationship with the child care program, a number of injury prevention materials and train-the-trainer educational programs have been made available to approximately110 local public health agencies that conduct health and safety consultation with child care providers around the state. In addition, the Injury and Violence Prevention program provides articles about specific injury issues for the quarterly child care newsletter.

/2008/
The MCH Coordinated Systems contracts with LPHAs will be renewed with three MCH health issues addressed. Reducing Intentional and Unintentional Injuries will be the focus of some contracts with population-based services and community initiatives addressing injury prevention in the MCH population.
//2008//

/2009/
Local CCR&R's provide training to child care providers on Recognizing and Reporting Child Abuse and Neglect.

In FFY 2007, the CCHC program provided 21 hours of group education to child care providers on child passenger safety; 50 hours on injury prevention in child care; 91 hours on emergency preparedness; 18 hours on poison prevention; and 14 hours on safe sleep. In addition 283 programs were provided to young children on injury prevention topics.
//2009//

/2010/
FFY 2008 CCHC gave 20 hours on child passenger safety; 56 hours on injury prevention in child care; 77 hours on emergency preparedness; 10 hours on poison prevention; and 16 hours on safe sleep. 467 programs to young children on injury prevention.

See Health Status Indicators #03A, 03B, 04A, 04B, and 04C.
//2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	59.0	62.6	55.0	47.2	47.2
Numerator	674	728	643	552	552
Denominator	1141490	1162408	1169209	1169228	1169228
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Source: DHSS. Missouri Information for Community Assessment (MICA) - Injuries, Patient Abstract System, & MICA-Population. Numerator is 2007 provisional injury data as a proxy for 2008. Denominator is population estimate of children age 14 year & under in 2007, as a proxy for 2008. 2008 data will be available November 2009.

The numerator is estimated by taking number of inpatient hospitalizations for unintentional injuries due to motor vehicle traffic and non-traffic crashes minus the number died from the injuries among children aged <=14 years.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Injury, MICA - Population, and the Bureau of Health Informatics, MO DHSS. 2007 data are not available yet, and 2006 data are used as proxy for 2007. 2007 final data will be available in December 2008.

The numerator is estimated by taking number of inpatient hospitalizations for unintentional injuries due to motor vehicle traffic and non-traffic crashes minus the number died from the injuries among children aged <=14 years.

Notes - 2006
2005 estimate substituted into denominator until more current information available.

Narrative:
/2010/
See Health Status Indicator #03A, 03B, 03C, 04A, and 04C.
//2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**

Annual Indicator	256.6	254.6	252.8	218.3	218.3
Numerator	2143	2100	2062	1777	1777
Denominator	835011	824951	815536	813974	813974
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Source: DHSS. Missouri Information for Community Assessment (MICA) - Injuries, Patient Abstract System, & MICA-Population. Numerator is 2007 provisional injury data as a proxy for 2008. Denominator is population estimate of youth aged 15-24 in 2007, as a proxy for 2008. 2008 data will be available November 2009.

The numerator is estimated by taking number of inpatient hospitalizations for unintentional injuries due to motor vehicle traffic and non-traffic crashes minus the number died from the injuries among youth aged 15-24.

Notes - 2007
Source: Missouri Information for Community Assessment (MICA) - Injury, MICA - Population, and the Bureau of Health Informatics, MO DHSS. 2007 data are not available yet, and 2006 data are used as proxy for 2007. 2007 final data will be available in December 2008.

The numerator is estimated by taking number of inpatient hospitalizations for unintentional injuries due to motor vehicle traffic and non-traffic crashes minus the number died from the injuries among youth aged 15-24 years.

Notes - 2006
2005 estimate substituted into denominator until more current information available.

Narrative:
/2010/
Safe Kids Missouri--The program contracts with nine local Safe Kids coalitions in Missouri to assist with building local infrastructure.

During FY 2008 with MCH funds, the Safe Kids coalitions were able to reach a population of 94,240. During FY2008, MCH funds were also used to support a leadership workshop for the coordinators and other members of the eight local Safe Kids coalitions.

See Health Status Indicator #03A, 03B, 03C, 04A, and 04B.
//2010//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	33.5	34.4	34.3	34.8	37.4
Numerator	6762	6856	6909	7027	7549

Denominator	201738	199543	201137	202081	202081
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: DHSS Center for Disease Control & Environmental Epi Denominator is 2007 US Census estimate of women age 15-19 years. 2008 population estimate will be available in November 2009. Numerator is from the Epidemiologic Profiles of HIV/AIDS and STDs in Missouri. Numerator is the number of reported cases in women ages 15-19 years in 2008. It is not the number of women with chlamydia diagnosis.

Notes - 2007
Numerator is obtained from the Epidemiologic Profiles of HIV/AIDS and STDs in Missouri; denominator population estimate for women aged 15-19 years in 2007 is not available yet, and the 2006 estimate is used as a proxy for 2007. 2007 population estimate for specific age groups will be available in November 2008.

Notes - 2006
2005 estimate substituted into denominator until more current information available.

Narrative:
Programs and activities that strive to improve the health of pregnant women and access to care:
-Home Visiting
-TEL-LINK
-ATODPA
-Newborn Health
-Alternatives to Abortion

/2009/
The Missouri Infertility Prevention Project (MIPP) is a partnership between DHSS and the Missouri Family Health Council (Title X Family Planning). Per CDC guidance, MIPP provides annual chlamydia/gonorrhea screening for women 25 years old and younger and older women and men with signs/symptoms and/or risk factors through Family Planning and STD clinics. A limited supply of medications is available for treatment.

The Syphilis Elimination Effort (SEE) aims to reduce the rate of syphilis in Missouri through outreach screening and educational events, social marketing campaigns, increased clinical setting screening and the active investigation of each reactive test reported. The current outbreak has primarily been among men who have sex with men (MSM), but recently there has been an increase in heterosexual exposures, including commercial sex workers. There are regional increases in heterosexual transmission of syphilis, starting first in Kansas City and expected next in the St. Louis metropolitan area. African American women continue to be at risk. The Bureau provides free testing and treatment for syphilis to LPHAs, family planning providers and community health centers. An epidemiological investigation occurs for each new case to identify and notify sex partners to offer testing and treatment. The project has far-reaching public health benefits by reducing two serious consequences of syphilis, i.e., HIV transmission and serious complications in pregnancy and childbirth.

The Bureau collaborates with the Missouri Department of Corrections and metropolitan jails to provide screening and treatment opportunities for offenders, including women. Adolescent

females are screened for chlamydia in metropolitan juvenile detention facilities.
//2009//

/2010/
The Adolescent Health Program and Bureau of HIV, STD, and Hepatitis, state department of education HIV Prevention Education and Health Education programs, and national partners are collaborating on a new initiative to advance Missouri efforts to increase capacity around HIV, STD, and teen pregnancy prevention. The action plan calls for identifying and serving youth in non-traditional public education settings; promoting medically accurate education, evidence-based approaches and characteristics of effective programs; and implementing youth development strategies.

The Adolescent Health program is collaborating with the Bureau of HIV, STD and Hepatitis on a social marketing campaign targeted for youth (Facebook, Twitter) and also participates in a Youth Advisory Council for these particular communicable diseases. In addition, these programs are participating in 2 technical assistance grants focusing on implementation of evidence-based interventions to prevent teen pregnancy, STDs, HIV and Hepatitis.

See Health Status Indicator #05B.
//2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	8.9	9.3	9.6	9.7	10.2
Numerator	9006	9256	9542	9625	10126
Denominator	1008252	1000208	996798	989565	989565
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: DHSS Center for Disease Control & Environmental Epi Denominator is 2007 US Census estimate of women age 20-44 years. 2008 population estimate will be available in November 2009. From the Numerator is from the Epidemiologic Profiles of HIV/AIDS and STDs in Missouri. Numerator is the number of reported cases in women ages 20-44 years in 2008. It is not the number of women with chlamydia diagnosis.

Notes - 2007
Numerator is obtained from the Epidemiologic Profiles of HIV/AIDS and STDs in Missouri; denominator population estimate for women aged 20-44 years in 2007 is not available yet, and the 2006 estimate is used as a proxy for 2007. 2007 population estimate for specific age groups will be available in November 2008.

Notes - 2006
2005 estimate substituted into denominator until more current information available.

Narrative:
/2009/
DHSS's Bureau of HIV, STD, and Hepatitis is dedicated to the prevention and intervention of sexually transmitted infections, including syphilis, chlamydia, gonorrhea, HIV/AIDS, hepatitis B and hepatitis C. STDs can have many serious consequences for pregnant women (e.g., ectopic pregnancies and infertility) and for fetus and infants (e.g., stillbirth, preterm births, neonatal sepsis and congenital abnormalities). Preventing the spread of infection between mother and child continues to be of the highest priority. Missouri statute 210.030 requires every pregnant woman, if she consents, to be tested for syphilis and hepatitis B. In addition, CDC and DHSS recommend testing for HIV, chlamydia and gonorrhea during pregnancy.

The Bureau's Perinatal Disease Prevention Program offers approximately six "One is Too Many" presentations per year targeting LPHAs, OB-GYN and birthing center staff and the general medical community. The focus of the presentation is to promote CDC and DHSS guidelines regarding screening/testing, treatment, prophylaxis, vaccinations, disease case reporting and follow up of pregnant women and their infant(s). In addition, between 2005 and year to date 2008, 51 of Missouri's 75 birthing hospitals have been visited and evaluated by the program.
//2009//

OOE provides epidemiologic leadership and expertise for DHSS divisions and centers, LPHAs and other stakeholders and partners to enhance health and safety of Missouri citizens. OOE has a full-time epidemiologist assigned to HFY and provides epidemiologic consultation on all MCH issues.

Some projects for which OOE plays the lead role are: State Infant Mortality Collaborative; PPOR analyses; MoPRA, a PRAMS-like survey and application for PRAMS funding; Fetal Alcohol Syndrome surveillance; autism surveillance; surveillance of TBI among children and adolescents and application for research funding; design and implementation of a methodology to determine new state priorities; MCH research agenda for Missouri; investigations of perceived clusters of adverse MCH events; and evaluation of several MCH programs.

BHI is primary source for health data within the state. BHI oversees the statistical support and health care assurance activities of DHSS; collects, analyzes and distributes health-related information that promotes better understanding of health problems and needs in Missouri; and highlights improvements and progress achieved in the general health status of Missourians. To assure uniform and consistent reporting of all Title V related data, DCPH Director's Office works with ITSD to integrate the eleven core health systems capacity indicators and some of the health status indicators into MOHSAIC.

/2010/
Reported rates of Chlamydia are higher in Missouri than nationwide in 2007 (398.9 vs. 370.2 per 100,000 and 169.0 vs. 118.9 per 100,000 respectively). Missouri ranked 16th in Chlamydia in 2007. 18 DIS with EPHP are located across the state.

See Health Status Indicator #05A.
//2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL	**Total All**	**White**	**Black or African**	**American Indian or**	**Asian**	**Native Hawaiian**	**More than**	**Other and**

POPULATION BY RACE	**Races**		**American**	**Native Alaskan**		**or Other Pacific Islander**	**one race reported**	**Unknown**
Infants 0 to 1	81883	66103	12665	0	0	0	0	3115
Children 1 through 4	311294	253579	50479	0	0	0	0	7236
Children 5 through 9	383005	315513	57936	0	0	0	0	9556
Children 10 through 14	393046	323281	60854	0	0	0	0	8911
Children 15 through 19	414182	341641	63965	0	0	0	0	8576
Children 20 through 24	399792	335404	54580	0	0	0	0	9808
Children 0 through 24	1983202	1635521	300479	0	0	0	0	47202

Notes - 2010
Source: DHSS Missouri Information for Community Assessment (MICA)
-Population 2007 estimates.

Source: DHSS Missouri Information for Community Assessment (MICA)
Population 2007 estimates.

Source: DHSS Missouri Information for Community Assessment (MICA)
Population 2007 estimates.

Source: DHSS Missouri Information for Community Assessment (MICA)
Population 2007 estimates.

Source: DHSS Missouri Information for Community Assessment (MICA)
Population 2007 estimates.

Source: DHSS Missouri Information for Community Assessment (MICA)
Population 2007 estimates.

Narrative:
The oldest among the "Echo-Boomer" or "Generation Y" birth cohort reached 20 years of age in 1998 and have since swelled the 20-24 age range White population. The same trend is seen among the African-American population.

/2008/
White population aged 20-24 years has increased by 20.1% during 1997-2005, from 296,383 to 356,016.

African-American population aged 20-24 years has increased by 26.1% during 1997-2005, from 44,887 to 56,596.
//2008//

/2009/
White population aged 20-24 years has increased by 16.5% during 1997-2006, from 296,383 to 345,199.

African-American population aged 20-24 years has increased by 23.6% during 1997-2006,from

44,887to 55,482.
//2009//

/2010/
White population aged 20-24 years has increased by 13.2% during 1997-2007, from 296,383 to 335,404.

African-American population aged 20-24 years has increased by 21.6% during 1997-2007, from 44,887 to 54,580.
//2010//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	77218	4665	0
Children 1 through 4	294158	17136	0
Children 5 through 9	364175	18830	0
Children 10 through 14	376815	16231	0
Children 15 through 19	399939	14243	0
Children 20 through 24	385409	14383	0
Children 0 through 24	1897714	85488	0

Notes - 2010
Source: DHSS Missouri Information for Community Assessment (MICA)
Population 2007 estimates.

Source: DHSS Missouri Information for Community Assessment (MICA)
Population 2007 estimates.

Source: DHSS Missouri Information for Community Assessment (MICA)
Population 2007 estimates.

Source: DHSS Missouri Information for Community Assessment (MICA)
Population 2007 estimates.

Source: DHSS Missouri Information for Community Assessment (MICA)
Population 2007 estimates.

Source: DHSS Missouri Information for Community Assessment (MICA)
Population 2007 estimates.

Narrative:
Total Hispanic population in Missouri has increase by 137% during 1990-2004, across the board growth in all age groups, reflects increase Hispanic immigration into Missouri.

/2008/
The total Hispanic population in Missouri has increased by 157% during 1990-2005, from 60,429

to 155,519, showing significant growth in all age groups, and reflects increased Hispanic immigration into Missouri.
//2008//

/2009/
The total Hispanic population in Missouri has increased by 172% during 1990-2006, from 60,429 to 164,194, showing significant growth in all age groups, and reflects increased Hispanic immigration into Missouri.
//2009//

/2010/
The total Hispanic population in Missouri has increased by 195.3% during 1990-2007, from 60,429 to 178,421, showing significant growth in all age groups, and reflects increased Hispanic immigration into Missouri.
//2010//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	92	40	50	0	0	0	1	1
Women 15 through 17	2654	1764	834	11	10	12	9	14
Women 18 through 19	6487	4776	1542	50	30	22	24	43
Women 20 through 34	63229	51425	9201	328	965	694	89	527
Women 35 or older	8396	6985	879	29	281	146	7	69
Women of all ages	80858	64990	12506	418	1286	874	130	654

Notes - 2010
Source: DHSS Vital Statistics. Provisional live birth numbers as of April 2009. Final numbers will be available September 2009.

Row "women of all ages" does not include women with unknown age.

Narrative:
/2010/
Total live births decreased by 1% from 2007 to 2008 (provisional). Proportion of births to women <=17 was 7.1% in Blacks while 2.8% in Whites in 2008. Compared to 2000 birth rate (per 1,000) for all races, 2007 rate decreased in teens <=17 while increased across other age groups:
10-14: 0.7 vs. 0.6
15-17: 26.7 vs. 21.4

18-19: 80.4 vs. 85.2
20-34: 104.3 vs. 109.5
35-44: 18.5 vs. 20.8

The Adolescent Health program has implemented a statewide media campaign to encourage parents and adolescents to talk to each other about relationships, sex, abstinence and other healthy decisions to reduce teenage pregnancies.

The Home Visiting programs continue to provide education on spacing and parenting skills.
//2010//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	81	11	0
Women 15 through 17	2434	219	1
Women 18 through 19	6077	402	8
Women 20 through 34	59682	3439	108
Women 35 or older	7927	448	21
Women of all ages	76201	4519	138

Notes - 2010
Source: DHSS Vital Statistics. Provisional live birth numbers as of April 2009. Final numbers will be available September 2009.

Row "women of all ages" does not include women with unknown age.

Narrative:
/2010/
Live births to Hispanics decreased by 3% from 2007 to 2008 (provisional). Proportion of births to women <=17 was 5.1% in Hispanics while 3.3% in Non-Hispanics in 2008. Compared to 2000 birth rate (per 1,000) in Hispanics, 2007 rate unchanged in teens 15-17 while increased across other age groups:
15-17: 48.6 vs. 48.5
18-19: 118.4 vs. 171.5
20-34: 137.8 vs. 168.4
35-44: 31.9 vs. 36.7

The Adolescent Health program has implemented a statewide media campaign to encourage parents and adolescents to talk to each other about relationships, sex, abstinence and other healthy decisions to reduce teenage pregnancies. Materials will be provided in Spanish to reach the Hispanic population.

The Home Visiting programs will continue to provide education on spacing and parenting

skills to the Hispanic population.
//2010//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	571	381	182	1	3	0	2	2
Children 1 through 4	95	71	23	0	0	0	1	0
Children 5 through 9	48	34	11	2	0	0	0	1
Children 10 through 14	69	53	15	0	0	0	0	1
Children 15 through 19	332	236	90	1	4	0	0	1
Children 20 through 24	406	306	99	0	1	0	0	0
Children 0 through 24	1521	1081	420	4	8	0	3	5

Notes - 2010
Source: DHSS Vital Statistics. Provisional infant death numbers as of April, 2009. Final numbers will be available September, 2009.

Source: DHSS Vital Statistics. Provisional death numbers as of April, 2009. Final numbers will be available October, 2009.

Source: DHSS Vital Statistics. Provisional death numbers as of April, 2009. Final numbers will be available September, 2009.

Source: DHSS Vital Statistics. Provisional death number as of April, 2009. Final numbers will be available September, 2009.

Source: DHSS Vital Statistics. Provisional death number as of April, 2009. Final numbers will be available September, 2009.

Source: DHSS Vital Statistics. Provisional death number as of April, 2009. Final numbers will be available September, 2009.

Narrative:
/2010/
Deaths of children 0-24 decreased from 1,608 in 2007 to 1,521 in 2008 (provisional). The decrease was across ages 0-14 and 20-24. Infant deaths decreased by 2% in Whites while 12% in Blacks.

The IVPP will continue to work with School Health, Adolescent Health and Newborn Health programs to promote injury prevention activities. New strategies to reduce injuries are to

collaborate with the Child Fatality Review Team and the State Training Team to develop additional activities and strategies.
//2010//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	547	23	1
Children 1 through 4	92	3	0
Children 5 through 9	46	2	0
Children 10 through 14	64	4	1
Children 15 through 19	324	8	0
Children 20 through 24	400	6	0
Children 0 through 24	1473	46	2

Notes - 2010
Source: DHSS Vital Statistics. Provisional infant death number as of April, 2009. Final numbers will be available September, 2009.

Source: DHSS Vital Statistics. Provisional death number as of April, 2009. Final numbers will be available September, 2009.

Source: DHSS Vital Statistics. Provisional death number as of April, 2009. Final numbers will be available September, 2009.

Source: DHSS Vital Statistics. Provisional death number as of April, 2009. Final numbers will be available September, 2009.

Source: DHSS Vital Statistics. Provisional death number as of April, 2009. Final numbers will be available September, 2009.

Source: DHSS Vital Statistics. Provisional death number as of April, 2009. Final numbers will be available September, 2009.

Narrative:
/2010/
Deaths of Hispanic children 0-24 decreased from 60 in 2007 to 46 in 2008 (provisional). Hispanic infant deaths decreased by 17.9%.

The IVPP will continue to work with School Health, Adolescent Health and Newborn Health programs to promote injury prevention activities. Promotional programs and materials will be made available in Spanish. New strategies to reduce injuries are to collaborate with the Child Fatality Review Team and the State Training Team to develop additional activities and strategies.
//2010//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	1583410	1300117	245899	9544	27850	0	0	0	2007
Percent in household headed by single parent	32.7	25.8	68.9	55.1	24.7	0.0	45.7	0.0	2007
Percent in TANF (Grant) families	7.6	5.3	19.2	4.3	1.2	0.0	0.0	0.0	2008
Number enrolled in Medicaid	506679	340430	147257	1401	4093	753	3325	9420	2008
Number enrolled in SCHIP	107321	80350	22759	248	1177	88	309	2390	2008
Number living in foster home care	14528	9955	4208	37	29	19	131	149	2008
Number enrolled in food stamp program	476976	304150	157366	1622	2324	678	2984	7852	2008
Number enrolled in WIC	152662	99473	32770	249	1779	0	1907	16484	2008
Rate (per 100,000) of juvenile crime arrests	4382.0	3552.2	8363.1	984.9	890.4	0.0	0.0	0.0	2007
Percentage of high school drop-outs (grade 9 through 12)	4.2	3.1	9.0	3.7	2.3	0.0	0.0	0.0	2008

Notes - 2010

Source: Bridged 2007 population estimates from the National Center for Health Statistics. The number under category Asian includes numbers under categories Asian/Native Hawaiian/other Pacific Islander.
Total for more than one race reported was not available.

Source: US Census Bureau. American Community Survey 2007. Table S0901. The numerator was single parent households with children under 18 years of age and denominator was all households with children under 18 years of age.

Number of TANF recipients aged 0-19 years served in State FY 2008 was obtained from the Missouri Department of Social Services, Research & Evaluation Unit.

Non SCHIP Medicaid children 0-19 years of age served in State FY 2008: Missouri Department of Social Services, Research & Evaluation Unit.

SCHIP children Age 0-19 years of age served in State FY 2008: Missouri Department of Social Services, Research & Evaluation Unit.

SCHIP in Missouri is an extension of MO HealthNet (Medicaid),

Number of food stamp recipients aged 0-19 years served in State FY 2008 was obtained from the Missouri Department of Social Services, Research & Evaluation Unit.

Number enrolled in WIC: Number of children aged <5 years enrolled in WIC in CY 2007. Data source: CDC. 2008 Pediatric Nutrition Surveillance System (PedNSS), Missouri - Summary of Demographic Indicators.
Race classifications defined for HSI # 9 are not completely comparable with those applied by the PedNSS data report. White category only included Non-Hispanic White; Black category only included Non-Hispanic Black; Asian category included Asian/Pacific Islander; Other and Unknown category (HSI#9A) included Hispanic and Other/Unknown categories.

Source: Dept of Social Services (possible duplicates) from calendar year 2007. Duplicates are due to inconsistencies between circuits and counties. Represents juvenile referrals only-not arrests.

Drop out rate is 2008 federal fiscal year (July 1, 2007-Sept 2008) from the Dept of Elementary & Secondary Education.

Highschool drop out rate is the number of drop outs divided by (September enrollment plus transfers in minus transfers out minus dropouts added to total September enrollment then divided by two).

Number of children living in foster home care served in State FY 2008 was obtained from the Missouri Department of Social Services, Research & Evaluation Unit.

Narrative:
/2010/
Proportion of children in TANF families decreased from 8.1% in 2007 to 7.6% in 2008. Children in WIC increased by 6.6% from 143,234 in 2007 to 152,662 in 2008. High school dropout rate in Blacks increased from 6.6% in 2007 to 9% in 2008.

The Home Visiting and Alternative to Abortion program, as well as Tel-Link will continue educating on availability of other state programs to improve the referral process. //2010//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	1512305	71105	0	2007
Percent in household headed	25.3	36.9	0.0	2007

by single parent				
Percent in TANF (Grant) families	7.5	8.4	0.0	2008
Number enrolled in Medicaid	470973	32584	3122	2008
Number enrolled in SCHIP	100685	5729	907	2008
Number living in foster home care	13853	454	221	2008
Number enrolled in food stamp program	451372	22680	2924	2008
Number enrolled in WIC	136178	16453	31	2008
Rate (per 100,000) of juvenile crime arrests	4514.1	1572.3	0.0	2007
Percentage of high school drop-outs (grade 9 through 12)	3.9	6.9	0.0	2008

Notes - 2010
Source: Bridged 2007 population estimates from the National Center for Health Statistics

Source: US Census Bureau's American Community Survey 2007 The numerator was single parent households with children under 18 years of age and denominator was all households with children under 18 years of age.

Number of TANF recipients aged 0-19 years served in State FY 2008 was obtained from the Missouri Department of Social Services, Research & Evaluation Unit.

Non SCHIP Medicaid children 0-19 years of age served in State FY 2008: Missouri Department of Social Services, Research & Evaluation Unit.

Hispanic & Non hispanic SCHIP children Age 0-19 years of age served in State FY 2008: Missouri Department of Social Services, Research & Evaluation Unit.

SCHIP in Missouri is an extension of MO HealthNet (Medicaid),

Number of food stamp recipients aged 0-19 years served in State FY 2008 was obtained from the Missouri Department of Social Services, Research & Evaluation Unit.

Number enrolled in WIC: Number of children aged <5 years enrolled in WIC in CY 2007. Data source: CDC. 2007 Pediatric Nutrition Surveillance System (PNSS), Missouri - Summary of Demographic Indicators.
Race classifications defined for HSI # 9 may not be completely comparable with those applied by the PNSS data report:

Source: Dept of Social Services (possible duplicates) from calendar year 2007. Duplicates are due to inconsistencies between circuits and counties. Represents juvenile referrals only-not arrests.

Hispanic/nonhispanic drop out rate is 2008 federal fiscal year (July 1, 2007-Sept 2008) from the Dept of Elementary & Secondary Education.

Highschool drop out rate is the number of dropouts divided by (September enrollment plus transfers in minus transfers out minus dropouts added to total September enrollment then divided by two).

Number of children living in foster home care served in State FY 2008 was obtained from the Missouri Department of Social Services, Research & Evaluation Unit.

Narrative:
/2010/
Among children 0-19, proportion of Hispanics increased from 4.2% in 2006 to 4.5% in 2007. From 2007 to 2008, proportion of Hispanic children increased in Medicaid (4.6% vs. 6.4%), SCHIP (5.1% vs. 5.3%), foster home care (3.0% vs. 3.1%), and food stamp program (4.4% vs. 4.8%).

The Home Visiting and Alternative to Abortion program, as well as Tel-Link will continue educating on availability of other state programs to improve the referral process. Education will continue in Spanish to reach the Hispanic population.
//2010//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	1175901
Living in urban areas	1080767
Living in rural areas	502643
Living in frontier areas	0
Total - all children 0 through 19	1583410

Notes - 2010
Source: US Census, Population Estimate Branch. Metropolitan area is based on metropolitan statistical area counties in 2003.

Source: US Census Bureau. American Community Survey 2007.
The urban/rural number for 2007 was estimated using the 2007 population estimate and an estimated urban/rural split for 2007, which was extrapolated from the urban/rural splits for the 1990 and 2000 Census.

Source: US Census. American Community Survey

Narrative:
/2010/
Metropolitan area is based on metropolitan statistical area (MSA) counties defined by US Census. Urban/rural definition is based on population density collected by US Census.

Continue to improve access to available services.
//2010//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	5783227.0
Percent Below: 50% of poverty	4.7
100% of poverty	12.8
200% of poverty	30.5

Notes - 2010
Source: US Census. Current Population Survey, Annual Social and Economic Supplement, 2008.
CPS Table Creator: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Source: US Census. Current Population Survey, Annual Social and Economic Supplement, 2008.
CPS Table Creator: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Narrative:
The mission of Missouri Reentry Process (MRP) Interagency Steering Team on which DHSS serves is to integrate successful offender reentry principles and practices in state agencies and communities resulting in partnerships that enhance offender self-sufficiency, reduce reincarceration and improve public safety.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	1555206.0
Percent Below: 50% of poverty	8.6
100% of poverty	21.9
200% of poverty	41.7

Notes - 2010
Source: US Census. Current Population Survey, Annual Social and Economic Supplement, 2008.
CPS Table Creator: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Source: US Census. Current Population Survey, Annual Social and Economic Supplement, 2008.
CPS Table Creator: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Narrative:
The Bureau of Immunization, Assessment and Assurance, supported by Title V agency, operates through a CDC grant and provides vaccine for eligible Missouri children through the Vaccines for Children (VFC) Program. The state's success at ensuring Missouri's children are up-to-date with recommended vaccines is monitored through clinical, school and day care assessments by field staff and the immunization registry. Vaccine safety is monitored by site visits of field staff to VFC provider clinics and county health departments. In addition, yearly influenza outbreaks are monitored through the Sentinel Physician's Network. These Missouri physicians provide specimens to the state public health laboratory for validation of influenza.

The Bureau of Environmental Epidemiology is involved in the investigation and prevention of illnesses and medical conditions related to the environment. The bureau's efforts focus on illnesses and medical conditions associated with exposure to chemical, bacteriological and physical agents in our environment and in water we consume including implementation of the state Childhood and Adult Lead Poisoning Prevention Programs and administering lead grants from CDC and the Environmental Protection Agency.

F. Other Program Activities

TEL-LINK, (1-800-TEL-LINK [800-835-5465]), DHSS toll-free information and referral telephone line for maternal, child and family health services, provides referrals and may transfer callers immediately to appropriate agency in local communities or statewide.

/2007/
TEL-LINK Web site, was developed January 2005 and had 9,984 hits in 2005. Collaboration with other state programs and agencies was developed to promote TELLINK and other health care benefits. Outreach was provided through direct mailings and exhibits at conferences and health fairs to promote TEL-LINK and distribute health educational materials.
//2007//

/2008/
In 2006 promotion of TEL-LINK was provided through direct mailings, distribution of health education materials and exhibits at conferences and health fairs. Toll free number was utilized with other state health programs such as Cancer and Chronic Disease Control. TEL-LINK Web page continues and has from DHSS home page.
//2008//

/2009/
In 2007 promotion of TEL-LINK continued and collaboration included Genetics and Healthy Childhood, WIC and Nutrition Services and Prevent Child Abuse Missouri. TEL-LINK Web page continues with a link from DHSS home page. Special emphasis was given to promoting TEL-LINK to minority populations in St. Louis through Minority Infant Mortality Reduction Campaign. Marketing efforts in Kansas City area targeted Spanish speaking individuals.
//2009//

/2010/
TEL-LINK special emphasis in St. Louis area.
//2010//

MINORITY HEALTH DISPARITIES
Infant death rates in Missouri have remained stagnant for past 10 years, maintaining large racial disparity for African American infants. State's overall infant mortality rate is just above national average.

Because over 60% of African-American births in Missouri occur in St. Louis metropolitan area, it is imperative that additional attention and resources be channeled to this most needy of communities.

/2009/
In May 2008 OMH through collaborative agreement with MFH released STATE OF MISSOURI HEALTH DISPARITIES REPORT: PROMOTING HEALTH EQUITY & REDUCING HEALTH DISPARITIES IN MISSOURI. It revealed substantial inequities among ethnic/racial and other vulnerable Missouri groups. OMH held focus groups with minority groups to reveal barriers. Report ended with series of standards issued as guidelines to health care organizations to lessen occurrence of health disparities in Missouri. See attachment to Needs Assessment section.

In 2007 GHC conducted intense media campaign in high risk zip codes of St. Louis City on issues of Breastfeeding, Safe Sleep and Folic Acid. Campaign involved television and radio advertisements, posters, bus-boards, billboards and distribution of campaign materials through nurse from SIDS Resources who made personal visits to churches and small businesses in the high-risk St. Louis zip codes to promote these messages.
//2009//

Proposed Intervention Strategy: DHSS will create partnership with CDC-Prevention Research Center at St. Louis University, St. Louis Maternal Child Health Coalition and MFH and request technical assistance from HRSA. DHSS will utilize evidence-based model to reduce infant mortality in zip codes at highest risk.

Building Blocks of Missouri (Old's Nurse Family Partnership Model) in St. Louis metropolitan area is intense, interpersonal pre-natal program that provides follow-up for 2 years following birth of child and helps low-income, first-time parents start their lives with their children on sound health course and prevent high-risk parenting behaviors.

GOVERNOR'S COUNCIL ON PHYSICAL FITNESS AND HEALTH (www.fitness.mo.gov/)

Council strives to promote exercising regularly, eating nutritiously and making healthy lifestyle choices by implementing programs, fostering communication and cooperation and developing statewide support. Council oversees such things as Shape Up Missouri/Moving Across America State by State, Show-Me Body Walk, and National Employee Health and Fitness Day, Show-Me State Games. Bureau of Health Promotion provides staff support for activities.

OBESITY CONFERENCE

Missouri Takes Action on Obesity Conference, held June 2006, was supported by Missouri Council for Activity and Nutrition (MoCAN), DHSS, MFH, Missouri Beef Council, Missouri Hospital Association, KC Healthy Kids, UM Extension and MediaCross, Inc.

OFFICE ON WOMEN'S HEALTH

OWH partnered with many St. Louis Organizations and national Sister to Sister organization for the 2nd annual Everyone has a Heart Campaign in St. Louis; St. Louis was 2nd in nation for attendance.

CARING FOR YOUR HEALTH (www.dhss.mo.gov/WomensHealth/Caring_for_your_health.pdf) was a collaboration: MCH Title V funding and women' advocacy groups throughout Missouri.

/2008/
OWH partner in St. Louis 3rd Sister to Sister Everyone Has a Heart Campaign, 1st in nation with 923 women screened.

CARING FOR YOUR HEALTH was translated into Spanish, www.dhss.mo.gov/WomensHealth/WomensHandbook-Spanish.pdf.

OWH with IVPP and UMC designed logo that will become national symbol to raise awareness of rape and sexual assault. Logo was made into lapel pin and placed on all materials prepared for Denim Day 2007 when 5 campuses and DHSS campus conducted organized activities. Department of Corrections stitched drawstring pants for care bags to go to Emergency Departments for rape victims.
//2008//

/2009/
OWH partnered in St. Louis 4th Sister to Sister Everyone Has a Heart Campaign for another successful heart health screening event. Data not yet available.

OWH developed and disseminated Denim Day Toolkits statewide to universities and colleges, crime victims advocates, Family and Consumer Science teachers and school health nurses with other state departments. Toolkits were sent nationally to states' OWH and Injury and Violence Prevention programs and DV coalitions. DMH, DESE, Public Safety and Corrections held Denim Day events.

//2009//

/2010/
OWH to hold 160 Denim Day events.
//2010//

/2010/
MISSOURI HEAD INJURY ADVISORY COUNCIL

The SHCN\AHI Program facilitates MHIAC. MHIAC is appointed by the Governor to represent consumers, families, professionals, schools, industry, state agencies.
//2010//

Alternatives to Abortion Program (A2A)

Additional funds were requested and obtained from the Missouri general assembly for expanding services of A2A Program for contractors for marketing the program statewide. The goals of A2A are:
1. Improved pregnancy outcomes by helping women practice sound health-related behaviors (decreasing cigarette use, alcohol and illegal drugs; improving nutrition, etc.);
2. Improved child health and development by helping parents provide more responsible and competent care for their children;
3. Improved families economic self sufficiency by helping parents develop vision for their own future, plan future pregnancies, continue their education and find jobs.

/2009/
In 2008 DHSS will launch media campaign through Hughes Group to promote services of A2A. Toll-free information and referral line has been established with implementation in March 2008.

Adolescent Health Program (AHP)

AHP developed statewide media campaign to encourage parents and adolescents to talk to each other about relationships, sex, abstinence and other healthy decisions. Campaign included materials, web links and aired radio and television spots; all are posted on DHSS Adolescent Health Web page www.dhss.mo.gov/AdolescentHealth. Title V Abstinence Education grant funds were for media spots.
//2009//

/2010/
AHP working to increase evidence-based approaches to prevent teen pregnancy, STDs, and HIV/AIDS. The Missouri State-Local Team was selected by AMCHP and NACCHO for a technical assistance grant. DHSS, Mississippi County Health Department and coalition working to get community support for pregnancy prevention programs in high need areas. Initiative with national MCH, STD, HIV, Health Education, and CDC partners to strengthen adolescent sexual health/related education issues.
//2010//

AIDS Drug Assistance Program (ADAP)

Bureau of HIV, STD and Hepatitis administers ADAP, Ryan White Title II, Housing Opportunities for People With AIDS (HOPWA) and Medicaid AIDS Waiver services to eligible low Income Missourians living with HIV with no other access to health care and supportive services.

Office of Epidemiology

OOE conducted epidemiological investigation (''An Epidemiologic Analysis of the Perceived

Excess in Infant and Fetal Deaths in St. Charles County, Missouri") on cluster of fetal and infant deaths in St. Charles County in 2003.

OOE assisted in identification and prioritization of MCH-related health problems and health risk behaviors for infants, children, adolescents and women of childbearing age using Priority MICA.

OOE conducted evaluation of Home Visiting program based on participants' perceived changes in satisfaction given in annual survey conducted 10/1/03-12/31/03.

G. Technical Assistance

Technical assistance requests under consideration include:
--Emergency preparation planning for hard to reach populations in Missouri to support the consolidation of Center for Emergency Response and Terrorism (CERT) within the Division of Community and Public Health.

--Evaluation of the CSHCN program.

--Assistance with grant application for Family Partnership Initiative.

--Affect on Poverty on MCH Indicators. While Missouri is 17th in the nation in relation to the 2000 U.S. Census population, the earnings for the state are not consistent with this population ranking. Technical assistance is needed to assist the state in determining the impact of poverty on MCH indicators and to help determine which indicators are/would be affected and in what way along with possible solutions to the issues.

--Medical Home (MH) Measure. Much has been written and discussed regarding MH in Missouri. Missouri has utilized several "factors" in selecting a best measure of "promotion of medical home", such as how many children have a primary care provider listed. Technical assistance from an outside source, such as the American Academy of Pediatrics, is being requested to identify specific measures of "medical home" to determine the "best" measure of "promotion of medical home" in Missouri.

/2009/
TAs have been submitted and approved to review infant mortality and evaluation of indicators for Missouri.

A consultant has been secured for the evaluation of performance measures with the first meeting occurring in July.

Missouri is still in the process of locating a consultant to provide technical assistance in identifying ways to improve healthy babies outcomes and reduce infant mortality.
//2009//

/2010/
July 22-24 2008, Mr. Jeffery Koshel, TA Consultant from HRSA visited Missouri DHSS, and provided suggestions and an evaluation report on the national/state performance measures. Please refer to the attachment for his report. Extended collaborative efforts have been made during development of future objectives of MCH measures among OOE, Vital Statistics, and MCH Programs. MCH Programs have taken the lead in setting appropriate objectives for all performance and outcome measures based upon the trend and comparison analyses developed by the MCH Epidemiology Response Team.
//2010//

An attachment is included in this section.

V. Budget Narrative

A. Expenditures

Missouri budgeted $24,460,806 million of partnership funds for the Federal Fiscal Year 2008 (FFY 2008) application and spent $23,860,406 including $12,739,380 in MCHBG funds towards MCH objectives in FFY 2008. MCHBG funds were budgeted at $13,406,174.

State funds expended were $11,121,026. State funded programs included direct health care and service coordination for cyshcn, alternatives to abortion services, School Health Services, TEL-LINK phone referral line, genetic services, sickle cell counseling, perinatal substance abuse and healthy babies initiatives, newborn hearing screening, the SAFE CARE Network, newborn screening and core public health assessment and system building. In addition medicaid income was earned to provide SC.

One-time state funding was utilized instead of MCH block funds, which resulted in a corresponding decrease in federal expenditures. Other areas also reflect a reduction in expenditures due to delays in filling positions, realignment of duties due to reorganization and the reduction in the related fringe benefits and administrative costs.

B. Budget

Please refer to the All Other Forms Section VI. Reporting Forms-General Information for the required Budget Forms 2, 3, 4, and 5. Estimates have been used in providing FFY 2010 budget details. In the case of "types of individuals served", the budget is based upon a percentage of breakdown by program and service area as to which types of individuals are impacted by the services provided. Form 5, State Title V Programs Budget and Expenditures by Types of Service, parallels the pyramid shown on Page 3 of the Attachment to Section IV. Priorities, Performance and Program Activities, A. Background and Overview, that organizes maternal and child health services hierarchically from direct health care services through infrastructure building.

B.2 Other Requirements

B.2.1. Maintenance of Effort

Missouri is in compliance with the maintenance of effort requirements described in Section 505(a)(4). Missouri has maintained and exceeded efforts of the 1989 program year.

B.2.2. Justification

The program budgets take into account the "30-30-10" requirements of Title V. In addition, Missouri uses a fair method to allocate Title V funds among individuals and areas identified as having unmet needs for maternal and child health services. The State uses its MCH Block Grant funds for the purposes outlined in Title V, Section 505 of the Social Security Act.

The FFY 2010 partnership budget is $2.2 million less than in FFY 2009. The reason for this change is the amount to be brought forward from FFY 2009 to FFY 2010 is anticipated to be less than the amount brought forward from FFY 2008 to FFY 2009. As a result of the second year reduction, the funding for some programs will be reduced in the FFY 2010 partnership:
--Alternative to Abortions
--School Health Services
--Adolescent Health
--Injury Prevention
--Local Public Health Service Contracts
--BSHCN Service Coordination
--Tel-Link

The Form 4 shows decreases in funding for all categories. Funding has decreased for Pregnant Women due to decreased funding for Alternatives to Abortion. A decrease in the Infant category is due to the decrease in funding for State Public Health Lab personal services and related fringe as well as Information Technology personal services and related fringe. The decrease in the Children category is due to decreased funding for decreased funding available for school health and personal services and related fringe. The CSHCN category has decreased due to the elimination of the Elks Mobile Dental Lab as well as decreases related to personal services and fringe. The Other category reflects decreases in funding for personnel costs and related fringe benefits as well as elimination of program evaluation funds.

The Form 5 shows a decrease in all levels. Direct Care funding decrease is due to elimination of the Elks Mobile Dental program and reduction in cyshcn payments. The Enabling category decrease is due to reduced funding budgeted for Alternatives to Abortion and reduction in personal services and related fringe for BSHCN service coordination. In Population Based Services, funding levels decreased for School Health, Adolescent Health, Tel-Link and Injury Prevention Programs. The infrastructure level decreased due to reduced funding budgeted for personal services and related fringe as well as reduced administrative funding due to overall reduced funding levels.

The FY2010 budget includes direct assistance funding for a CDC assigned epidemiologist. Budget and expenditures for this staff will be equally distributed across the following categories: Pregnant Women, Infants, Children, and Children with Special Healthcare Needs. All funds related to the CDC assignee will be shown in the Infrastructure Building Services.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.